STATE OF MICHIGAN
IN THE SUPREME COURT

SHIRLEY HAMILTON, as Personal Representative of the Estate of ROSALIE ACKLEY, Deceased,

Plaintiff-Appellee

and

BLUE CROSS/BLUE SHIELD OF MICHIGAN

Intervening Plaintiff

vs.

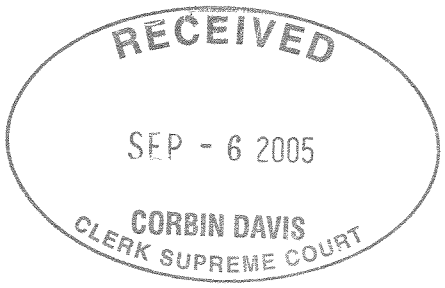
MARK F. KULIGOWSKI, D.O.,

Defendant-Appellant

Supreme Court No. 126275
Court of Appeals No. 244126
Lower Court No. 00-033440-NH

AMICUS CURIAE BRIEF OF MICHIGAN STATE MEDICAL SOCIETY

PROOF OF SERVICE



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STATEMENT OF BASIS FOR JURISDICTION

This case is before the Court pursuant to a July 12, 2005 Order granting leave to appeal.

STATEMENT OF QUESTIONS PRESENTED

I. Whether a standard of care expert witness who is board certified in internal medicine and devotes the majority of his professional time to the practice of infectious diseases is qualified under MCL 600.2169(1)(a) and (1)(b)(i) to testify against a defendant physician who specializes, is board certified in, and devotes the majority of his professional time to the practice of, internal medicine?

Plaintiff-Appellee says "yes."
Defendant-Appellant says "no."
Amicus Curiae MSMS says "no."

II. What is the proper construction of the words "specialist" and "that specialty" in MCL 600.2169(1)(a) and MCL 600.2169(1)(b)(i), and "active clinical practice" and "active clinical practice of that specialty" as those terms are used in MCL 600.2169(1)(b)(i)?

STATEMENT OF FACTS

The issues raised by this appeal involve the interpretation of a statute that governs the qualification of an expert witness to testify regarding the standard of care in a medical malpractice case against a *specialist.* The statute is part of the Michigan Tort Reform Act of 1993, P.A. 1993, No. 78, which was enacted as a follow-up to earlier tort reform legislation implemented in 1986. Michigan is one of over 30 states that have enacted expert witness qualification statutes.[1] The Michigan statute requires that an expert witness retained to give standard of care testimony for or against a defendant, specialize in the *same* specialty as the defendant if the defendant is a specialist; additionally, if the defendant-specialist is board certified, the expert must also be board certified in *that specialty*. MCL 600.2169(1)(a). Further, the expert must have *devoted a majority of his or her professional time to the active clinical practice of that specialty* and/or to *the instruction of students in the same specialty* during the year immediately preceding the occurrence that is the basis for the claim. MCL 600.2169(1)(b).

Amicus Curiae Michigan State Medical Society ("MSMS") is a professional association that represents the interests of over 14,000 physicians in the State of Michigan. Organized to promote and protect the public health and to preserve the interests of its members in the practice of medicine, MSMS has a pervasive interest in assuring that standard of care witnesses be trained and appropriately credentialed in the fields in which they testify. The statute is designed to accomplish that end. However, in *Hamilton v Kuligowski*, 261 Mich App 608; 684 NW2d 366 (2004) the Court of Appeals did not apply the statute as written.

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[1] Other states include: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Iowa, Kansas, Louisiana, Maryland, Mississippi, Montana, Nevada, New Hampshire, New Jersey, North Carolina, Ohio, Oklahoma, Rhode Island, South Carolina, Tennessee, Texas, Virginia, West Virginia. *See http://www.ncsl.org*

The complaint in *Hamilton* alleged that defendant "failed to identify the decedent as a high-risk stroke patient, 'undertake a prompt work up' for stroke, and 'make an urgent referral' after the decedent experienced pre-stroke symptoms." 261 Mich App at 609. Defendant Dr. Kuligowski was board certified in, and practiced, internal medicine. During the trial, Plaintiff called Dr. Arnold Markowitz as her standard of care expert. Dr. Markowitz testified that he was board-certified in internal medicine but had additional subspecialty training in, and devoted the majority of his medical practice to, infectious diseases. *Id.* at 609. Defendant thus moved to strike Dr. Markowitz as an expert because he did not devote the majority of his active clinical practice to the same specialty as Dr. Kuligowski, as required by MCL 600.2619(1)(b)(i). The Trial Court agreed that the active clinical practice requirement precluded Dr. Markowitz's testimony and entered a directed verdict for Dr. Kuligowski. *Id.* at 610. The Court of Appeals reversed, stating that it "declined defendant's invitation to graft a requirement for matching subspecialties onto the plain 'specialty' language of MCL 600.2169(1)." The Court said:

> In this case, defendant specialized in internal medicine, with a special emphasis on geriatric medicine. Dr. Markowitz also specialized in internal medicine, he simply focused on the different subspecialty of infectious diseases. Dr. Markowitz carefully explained, and plaintiff confirmed with documentation, that the subspecialty "infectious diseases" was a more focused application of internal medicine, but internal medicine nonetheless. He repeatedly explained that this practice was still entirely within the ambit of internal medicine. Defendant makes much of Dr. Markowitz's testimony that an "internist has a broader scope" of practice and he was "not sure what the average internist sees day in or day out." These statements were taken out of context from Dr. Markowitz's attempts to explain his use of his specialty and refrain from making speculative comparisons of his practice to the practice of other internists with varying subspecialties. He testified that all his patients saw him because of his status as a specialist in internal medicine. He explained that an infectious-diseases subspecialty merely allowed him to do more for his patients than the internal medicine specialty could alone. Defendant did not dispute this testimony. Therefore, the record reflects that Dr. Markowitz devoted the majority of his professional time to the "active

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(National Conference of State Legislatures, *State Medical Malpractice Tort Laws*; National Conference of State Legislatures, *2005 Enacted Medical Liability Legislation in the States*).

clinical practice" of defendant's internal medicine "specialty." The statute does not require more.

261 Mich App at 611.

As is more fully discussed below, a "subspecialty" is in fact a "specialty" within the meaning of the statute and the Court of Appeals erred in refusing to enforce the "same specialty" and "active clinical practice" requirements as written. Reversal of the Court of Appeals' decision is required.

ARGUMENT

STANDARD OF REVIEW

De novo review is accorded to questions of statutory interpretation. *Ayar v Foodland Distributors,* 472 Mich 713, 715; 698 NW2d 875 (2005); *Roberts v Mecosta County General Hospital,* 466 Mich 57, 62; 642 NW2d 663 (2002).

I. If the Defendant is a Board Certified Internal Medicine Specialist Who Devotes a Majority of His Professional Time to the Active Clinical Practice of Internal Medicine, An Expert Who is Board Certified in Internal Medicine but Devotes the Majority of His Professional Time to the Practice of Infectious Diseases is not Qualified Under MCL 600.2169 to Testify as to the Applicable Standard of Care.

The issues raised by this appeal involve the interpretation of a statute that governs the qualification of an expert witness in a medical malpractice case against a *specialist.* The statute, MCL 600.2169, requires that a standard of care witness for or against a defendant specialize in the *same* specialty as the defendant if the defendant is a specialist; additionally, if the defendant-specialist is board certified, the expert must also be board certified in *that specialty.* MCL 600.2169(1)(a). Further, the expert must have *devoted a majority of his or her professional time to the active clinical practice of that specialty* and/or to *the instruction of students in the same*

specialty, during the year immediately preceding the occurrence that is the basis for the claim. MCL 600.2169(1)(b).[2]

The Legislature's determination that the reliability of expert testimony requires a precise match between the specialties, board certifications and devotion to practice specialties of the expert and the defendant reflects the stringency of real world practice. The rapid advancement of medical science has necessitated increasing efforts by the medical profession to insure that physicians are properly trained in their practice areas. This frequently requires multiple levels of specialized training and certification within a particular field of medicine. While some may refer to these increasingly particularized medical fields as "subspecialties," the nomenclature is merely a matter of semantics. Sub-specialties are, in fact, specialties.

Medicine has extensively evolved into specialty practice. The American Board of Medical Specialties ("ABMS") consists of 24 member boards which develop and utilize professional and educational standards for the training, evaluation and credentialing of physicians in their respective specialty areas.[3] The American Osteopathic Association has 18 approved specialty boards.[4] Hospitals rely upon the credentialing and certification procedures of these boards, as well as numerous other certifying boards, such as the American Board of Oral

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[2] MCL 600.2169(c) governs expert testimony against a general practitioner and requires that the expert, in the year immediately preceding the occurrence that is the basis for the claim, have devoted a majority of his or her professional time to active clinical practice as a general practitioner or to the instruction of students. Further, the expert witness requirements are incorporated into MCL 600.2912d, which requires that a complaint asserting a claim for medical malpractice be accompanied by an affidavit of merit that attests to the validity of the claim. The affidavit must be signed by a health care professional that the plaintiff's attorney reasonably believes to satisfy the requirements for an expert witness prescribed by MCL 600.2169. Defendants are also required to file a similarly executed affidavit of meritorious defense. MCL 600.2912d.

[3] http:/www.abins.org/member.asp.

[4] *See e.g.*, http://www.osteopathic.org

and Maxillofacial Surgery, the American Board of Clinical Neurophysiology, and the American Society of Echocardiography, to screen, select, appoint and award hospital privileges to physicians.

A physician who lacks the training, experience and certification required to be credentialed by a hospital to perform a certain procedure or to practice a particular specialty is certainly not qualified to articulate the standard which governs that procedure or specialty in a court of law, and MCL 600.2169 recognizes the reliability need for matching board certifications. But matching board certifications do not end the inquiry. The statute goes further. The expert must also *specialize* in the *same* field as the defendant and devote a majority of his professional time to *active clinical practice* or instruction in that *specialty*.

These later requirements reflect the Legislature's recognition that matching board certification in a particular specialty may not reflect the real world practice experience of the defendant and the expert. This case is illustrative. Dr. Kuligowski and Plaintiff's expert, Dr. Arnold Markowitz, are both board certified in internal medicine. However, while Dr. Kuligowski actually specializes in internal medicine, Dr. Markowitz specializes in infectious disease. *See e.g., Nippa v Botsford General Hospital*, 251 Mich App 664, 666; 651 NW2d 103 (2002), *vacated on other grounds*, 468 Mich 882; 661 NW2d 231 (2003)(stating that Arnold Markowitz, M.D. "specializes in infectious diseases."). This infectious disease focus is one of numerous practice specialties that are within the broad umbrella of, but distinctly different from, a more general internal medicine practice. Other specialties certifiable by the American Board of Internal Medicine include: adolescent medicine, cardiovascular disease, clinical cardiac electrophysiology, critical care medicine, clinical and laboratory immunology, endocrinology, diabetes and metabolism, gastroenterology, geriatric medicine, hematology, interventional

cardiology, medical oncology, nephrology, pulmonary disease, rheumatology, and sports medicine.[5] The internal medicine origin of these specialties does not make them the same as internal medicine or the same as other internal medicine specialties. Having gone beyond the generality of an internal medicine specialty, these individuals - gastroenterologists, nephrologists, hematologists, oncologists, cardiologists, pulmonologists and the like - have in fact become specialists in another field subject to different standards of care.

The "standard of care" is a key element to the prosecution and defense of a medical malpractice case. In Michigan, the standard of care applicable to medical malpractice actions has been codified. MCL 600.2912a (with emphasis added) provides:

> In an action alleging malpractice the plaintiff shall have the burden of proving that in light of the state of the art existing at the time of the alleged malpractice:
>
> (a) The defendant, if a general practitioner, failed to provide the plaintiff the recognized standard of acceptable professional practice or care in the community in which the defendant practices or in a similar community, and that as a proximate result of the defendant failing to provide that standard, the plaintiff suffered an injury.
>
> (b) The defendant, if a *specialist*, failed to provide the recognized standard of practice or care within that *specialty* as reasonably applied in light of the facilities available in the community or other facilities reasonable available under the circumstances, and as a proximate result of the defendant failing to provide that standard, plaintiff suffered an injury.[6]

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[5] https://www.abim.org/resources/publications/whats_so_special.shtm

[6] In *Cox v Board of Hospital Managers for the City of Flint,* 467 Mich 1; 651 NW2d 356 (2002), this Court noted that the standard of care for specialists is frequently, but inaccurately referred to as a national standard of care. This Court explained:

> The plain language of subsection (b) states that the standard of care is that "within that specialty as reasonably applied in light of the facilities available in the community or other facilities reasonably available under the circumstances." ... Under the plain language of the statute, then, the standard of care for both general practitioners and specialists refers to the community."

Id. at 17 n 17.

This standard must be established by an expert witness who is familiar with the customary practice of the relevant population of professionals. As this Court recognized in *McDougall v Schanz,* 461 Mich 15, 36; 597 NW2d 148 (1999), the expert witness statute essentially modifies the standard of care element "to require that proof of malpractice 'emanate from sources of reliable character as defined by the Legislature'", quoting then Judge Taylor's dissenting Court of Appeals' opinion in *McDougall*, 218 Mich App at 518.

That wasn't always the case. Prior to 1986, MRE 702 was the sole determinant regarding the admissibility of expert testimony. At that time, the rule allowed a witness to give expert testimony if the witness was "qualified as an expert by knowledge, skill, experience, training, or education ..." [7] This standard gave Michigan courts fairly free rein to determine whether a proffered expert had the requisite familiarity with the standard of care to pass evidentiary muster. Indeed, familiarity with the standard of care was frequently articulated as the qualifying test.[8]

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[7] Amended effective January 1, 2004 to bring the admissibility of expert testimony in line with the federal standard established by the United States Supreme Court in *Daubert v. Merrell Dow Pharmaceuticals, Inc*, 509 US 579 (1993), MRE 702 now provides:

> If the court determines that scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education may testify thereto in the form of an opinion or otherwise if (1) the testimony is based on sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case.

[8] *See e.g., Dybata v Kistler,* 140 Mich App 65, 69; 362 NW2d 891 (1985); *Bahr v Harper-Grace Hospitals,* 198 Mich App 31, 34-35; 497 NW2d 526 (1993) *rev'd in part on other grounds* 448 Mich 135 (1995); *Siirila v Barrios,* 398 Mich 576, 593; 248 NW2d 171 (1976); *Francisco v Parchment Medical Clinic, P.C.,* 407 Mich 325, 327; 285 NW2d 39 (1979); *Callahan v William Beaumont Hospital,* 400 Mich 177, 180; 254 NW2d 31 (1977).

While courts traditionally examined the *specialty* of the defendant when determining whether the proffered expert was qualified to testify under MRE 702, the absence of specific guidelines led to an obvious lack of uniformity. Some courts found that an expert who did not specialize in the same field as the defendant was not sufficiently familiar with the applicable standard of care to testify. *See e.g., Swantek v Hutzel Hospital,* 115 Mich App 254, 259; 320 NW2d 234 (1982)(pediatric neurologist could not testify as to the standard of care of an obstetrician-gynecologist); *Dybata v Kistler, supra* n.8, (obstetrician-gynecologist is not sufficiently familiar with the standard of care governing a general practitioner); *Carlton v St John Hospital,* 182 Mich App 166, 171-172; 451 NW2d 543 (1989)(even though witness need not specialize in the field he is asked to testify about, cardiologist was not qualified to opine whether performance of surgery violated the standard of care applicable to a surgeon); *Dunn v Nundkumar,* 186 Mich App 51, 54; 463 NW2d 435 (1990)(even though expert need not specialize in the field he is asked to testify about, general surgeon and family practitioner was unqualified to testify regarding the standard of care governing an obstetrician-gynecologist). *See also, Dengler v State Farm Mutual Ins Co,* 135 Mich App 645, 649; 354 NW2d 294 (1984)(proffered expert who was not a specialist in neurology was not qualified to testify regarding a subarachnoid hemorrhage).

However, other courts allowed expert witnesses to testify *even absent credentials or experience in the defendant's specialty. See e.g., Wolak v Walczak,* 125 Mich App 271, 276; 335 NW2d 908 (1983)(obstetrician-gynecologist may testify about the effect of bilirubin in newborns); *Strach v St. John Hospital Corp,* 160 Mich App 251, 273; 408 NW2d 441 (1987)(board certified general surgeon permitted to testify against a thoracic surgeon); *Banks v Wittenberg,* 82 Mich App 274, 277; 266 NW2d 788 (1978)(urologist can testify regarding the

standard of care applicable to a general practitioner); *Wilson v W A Foote Memorial Hospital,* 91 Mich App 90, 101-102; 284 NW2d 126 (1979)(orthopedic surgeon permitted to testify regarding the standard of care of a hospital relative to the emergency nature of a breech presentation at birth); *Mazey v Adams,* 191 Mich App 328, 331; 477 NW2d 698 (1991)(internist with specialty in cardiology permitted to testify to standard of care of general practitioner); *Siirila v Barrios, supra,* and *Berwald v Kasal,* 102 Mich App 269, 276; 301 NW2d 499 (1980)(specialist may testify as to standard of care applicable to a general practitioner).

There was also a discrepancy in the requisite timeliness of the expert's knowledge. Some courts allowed experts to testify *despite their absence from the practice of medicine for a number of years. See e.g., Pietrzyk v Detroit,* 123 Mich App 244, 247-248; 333 NW2d 236 (1983)(medical doctor's 20-year absence from the emergency room setting did not preclude him from testifying about the standard of care in an emergency room); *Haisenleder v Reeder,* 114 Mich App 258, 265; 318 NW2d 634 (1982)(physician who had not practiced for 13 years in an emergency room setting was permitted to testify regarding the standard of care applicable to an emergency room physician). Other experts were disqualified because of their absence from practice. *Gilmore v O'Sullivan,* 106 Mich App 35, 39; 307 NW2d 695 (1981) (an expert who had not delivered a baby since 1959 nor performed surgery since 1967 could not testify regarding the standard of care applicable to an obstetrician-gynecologist).

Not surprisingly, these amorphous requirements for standard of care testimony led to a proliferation of circuit-riding "experts" who "practiced" only in the litigation arena. Their "pay-

for-what-you-want testimony" compromised the integrity of the judicial process and contributed to the malpractice crisis that prompted the need for tort reform.[9]

To address this problem, the 1986 enactment of MCL 600.2169 required that expert witnesses "actually practice" or "teach medicine" and have "firsthand practical expertise in the subject matter about which they are testifying." *Id.*[10] The 1986 version of the statute sought to

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[9] As the *Report of the Senate Select Committee on Civil Justice Reform* viewed the problem in Michigan:

> Testimony of expert witnesses is normally required to establish a cause of action for malpractice. Expert testimony is necessary to establish both the appropriate standard of care and the breach of that standard. There is currently no specific requirement for an expert witness to devote a specific percentage of time to the actual practice of medicine or teaching, or when testifying against a specialist that the expert actually practices or teaches in *that specialty*. Instead, a physician-witness is qualified to testify as an expert in Michigan, even though he/she does not practice in Michigan and is not of the same specialty, based on a mere showing of an acceptable background and a familiarity with the nature of the medical condition involved in the case. As a practical matter, in many courts merely a license to practice medicine is needed to become a medical expert on an issue.
>
> This has given rise to a group of national professional witnesses who travel the country routinely testifying for plaintiffs in malpractice actions. These "hired guns" advertise extensively in professional journals and compete fiercely with each other for the expert witness business. For many, testifying is a full-time occupation and they rarely actually engage in the practice of medicine. There is a perception that these so-called expert witnesses will testify to whatever someone pays the [sic] to testify about.

Id. at 28-29 (emphasis added).

[10] The *Senate Report* explained:

> In particular, with the malpractice crisis facing high-risk specialists, such as neurosurgeons, orthopedic surgeons and ob/gyns, this reform is necessary to insure that in malpractice suits against specialists, the expert witnesses actually practice in that same specialty. This will protect the integrity of our judicial system by requiring real experts instead of "hired guns."

Id. at 29.

do this by requiring that an expert testifying for or against a specialist, specialize in the same specialty *or a related relevant area of medicine* as the defendant in the action, and devote or have devoted at the time of the occurrence involved in the action, a substantial portion of his or her professional time to practice or teaching in that area.[11] The statute provided in relevant part:

> (1) In an action alleging medical malpractice, if the defendant is a specialist, a person shall not give expert testimony on the appropriate standard of care unless the person is or was a physician licensed to practice medicine or osteopathic medicine and surgery or a dentist licensed to practice dentistry in this or another state and meets both of the following criteria:
>
> (a) Specializes, or specialized at the time of the occurrence which is the basis for the action, *in the same specialty or a related, relevant area of medicine or osteopathic medicine and surgery or dentistry as the specialist who is the defendant* in the medical malpractice action.
>
> (b) Devotes, or devoted at the time of the occurrence which is the basis for the action, a substantial portion of his or her professional time to the active clinical practice of medicine or osteopathic medicine and surgery or the active clinical practice of dentistry, or to the instruction of students in an accredited medical school, osteopathic medical school, or dental school *in the same specialty or a related, relevant area of health care as the specialist who is the defendant* in the medical malpractice action.
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> * * *

Former MCL 600.2169 (emphasis added).

Although the 1986 statute tightened up the requirements for the qualification of experts, it was soon felt that the statute had not gone far enough and that more restrictive reforms were necessary. Thus, the 1993 amendments required that the proffered expert be currently licensed to practice medicine, practice in the same specialty as the defendant, and be board certified in that specialty if the defendant was board certified. The revised statute further required that the expert

devote the majority of his or her professional time to practice or instruction in that specialty. The statute, which is the statute presently before this Court, provides in pertinent part:

> (1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.
>
> (b) Subject to subdivision (c), during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:
>
> (i) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of that specialty.
>
> (ii) The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, an accredited health professional school or accredited residency or clinical research program in the same specialty.
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> * * *

[11] The statute was part of the Michigan Tort Reform Act of 1986, P.A. 1986, No. 178.

In *McDougall v Schanz,* 461 Mich 15; 597 NW2d 148 (1999), this Court upheld the constitutionality of the expert witness statute as a valid exercise of the Legislature's public policy-making prerogative, finding that the statute did not impermissibly infringe upon this Court's exclusive authority under the Michigan Constitution 1963, art 6, § 5, to promulgate rules governing practice and procedure in Michigan courts. Rather, this Court concluded that the statute was an enactment of "substantive law." 461 Mich at 18.[12] This Court explained:

> [W]e conclude that § 2169 is an enactment of substantive law. It reflects wide-ranging and substantial policy considerations relating to medical malpractice actions against specialists. We agree with the Court of Appeals dissent in *McDougall* that the statute
>
> > reflects a careful legislative balancing of policy considerations about the importance of the medical profession to the people of Michigan, the economic viability of medical specialists, the social costs of "defensive medicine," the availability and affordability of medical care and health insurance, the allocation of risks, the costs of malpractice insurance, and manifold other factors, including, no doubt, political factors – all matters well beyond the competence of the judiciary to reevaluate as justiciable issues. [218 Mich. App. at 518 (Taylor, PJ, dissenting).]

461 Mich at 35.

This Court considered the matching board certification requirement of Section 2169(1)(a) in *Halloran v Bhan*, 470 Mich 572; 683 NW2d 129 (2004). In that case, the proposed standard of care expert was board certified in anesthesiology and had a certificate of added qualification in critical care. The defendant physician was board certified in internal medicine with a certificate of added qualification in critical care. The parties agreed that the subspecialty certifications were not "board certifications" for purposes of the statute. Thus, because the defendant and the expert were not board certified in the same specialty, the majority concluded

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[12] The 1986 version of the statute was before this Court in *McDougall.* However, this Court stated that its ruling applied with equal force to the 1993 statute. 461 Mich at 21, n 2.

that the expert was not qualified to testify under the plain meaning of the statute. 470 Mich at 579.

In reaching this conclusion, the majority rejected the Court of Appeals' ruling that it was sufficient under the statute if the expert witness and the defendant doctor shared the same sub-specialty, stating that "'in spite of' the specialty requirement in the first sentence [of Section 2169(1)(a)], the witness must also share the same board certification as the party against whom or on whose behalf the testimony is offered." *Id.* at 578. In the context of the *Halloran* decision, the majority did not decide the inverse issue, which is presently before this Court - how the "same specialty" requirement is to be applied when the board certifications match but the sub-specialty practice areas do not. The dissenting opinions did not reach this issue either. However, the issue was addressed in part by the Court of Appeals in the post-*Halloran* case of *McQuire v Wasvary*, 2005 Mich App LEXIS 119 (2005). In that case, the defendant and the expert were both board certified in general surgery. The defendant, however, was a fellowship trained colon-rectal surgeon and exclusively practiced in the area of colon and rectal surgery, which the defendant characterized as a sub-specialty of general surgery. Giving effect to the defendant's sub-specialty practice, the Court held that the expert was not qualified to testify against the defendant. The Court explained:

> Moreover, we note that *MCL 600.2169* does not define or distinguish between specialist and subspecialists. However, the dictionary defines "specialist" as "a person devoted to one subject or to one particular branch of a subject or pursuit." *Random House Webster's College Dictionary* (2d ed), p 1260. Applying this definition to the statutory language, *Halloran, supra*, reveals that there is no such distinction where a specialist is devoted to a subject or a particular branch within a subject. Accordingly, this attempted distinction is without merit.

2005 Mich App LEXIS at *14 n 4.[13]

The plain language of Section 2169 requires more than matching board certifications. The specialties of the defendant and the standard of care expert must also be the "same," and the expert must devote a majority of his or her professional time to active clinical practice or instruction in the defendant's specialty. These later requirements could not be met in this case. For reasons more fully explained below, the Court of Appeals in *Hamilton* erred in its exclusion of sub-specialties from the definition of specialties and in failing to give effect to the active clinical practice requirement.[14]

A. The Rules of Statutory Construction Require that the Statute be Applied According to its Plain Meaning.

The foremost rule of statutory construction is that courts are to give effect to the legislative intent. *Halloran v Bhan,* 470 Mich at 577. This Court articulated and observed the applicable rules in *In re Certified Question, Henes Special Projects Procurement, Marketing and Consulting Corp v Continental Biomass Industries, Inc*, 468 Mich 109; 659 NW2d 597 (2003), a case certified by the Sixth Circuit to determine the standard for evaluating the mental state

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[13] A contrary conclusion was reached in the pre-*Halloran* case of *Watts v Canody,* 253 Mich App 468, 470; 655 NW2d 784 (2002).

[14] The expert witness qualification statute was also before this Court in *Grossman v Brown*, 470 Mich 593; 685 NW2d 198 (2003). In that case, the issue was whether the plaintiff's attorney had a reasonable belief under MCL 600.2912d(1) that the expert who signed an affidavit of merit on plaintiff's behalf satisfied the expert witness requirements of MCL 600.2169a. The defendant was board certified in general surgery and possessed a certificate of special qualification in vascular surgery. The expert was board certified in general surgery and specialized (but did not possess a certificate of added qualification) in vascular surgery. The majority held that given the information available to the plaintiff's attorney when he prepared the affidavit of merit, he had a reasonable belief that the doctors were both certified in general surgery and that there was no board certification in vascular surgery. The majority did not, however, decide whether the expert would be qualified to testify at trial and expressly declined to consider the additional issue of whether board certifications must match in all cases or only those in which the board certifications are relevant to the alleged malpractice. 470 Mich at 600, n 7.

required to assess double damages under the Michigan Sales Representative Commission Act. In addressing its task, this Court explained:

> A fundamental principle of statutory construction is that "a clear and unambiguous statute leaves no room for judicial construction or interpretation." *Coleman v Gurwin,* 443 Mich 59, 65; 503 NW2d 435 (1993). The statutory language must be read and understood in its grammatical context, unless it is clear that something different was intended. *Sun Valley Foods Co v Ward,* 460 Mich 230; 596 NW2d 119 (1999). When a legislature has unambiguously conveyed its intent in a statute, the statute speaks for itself and there is no need for judicial construction; the proper role of a court is simply to apply the terms of the statute to the circumstances in a particular case. *Turner v Auto Club Ins Ass'n,* 448 Mich 22, 27; 528 NW2d 681 (1995).

468 Mich at 113. *See also, Ayar v Foodland Distributors*, 472 Mich 713, 716; 698 NW2d 875 (2005)("Clear and unambiguous statutory language is given its plain meaning, and is enforced as written"); *Eggleston v Bio-Medical Applications of Detroit, Inc,* 468 Mich 29, 32; 658 NW2d 139 (2003)("If the language of a statute is clear, no further analysis is necessary or allowed"); *Roberts v Mecosta County General Hospital,* 466 Mich 57, 63; 642 NW2d 663 (2002)("a court may read nothing into an unambiguous statute that is not within the manifest intent of the Legislature as derived from the words of the statute itself."); *Omelenchuck v City of Warren,* 461 Mich 567, 575; 609 NW2d 177 (2000)(refusing to rewrite the tolling statute to add words to the statute); *Sun Valley Foods Co v Ward*, 460 Mich. 230, 236; 596 NW2d 119 (1999)(the Court's primary task of discerning and giving effect to the Legislative intent "begins by examining the language of the statute itself"); *People v Herron,* 464 Mich 593, 611; 628 NW2d 528 (2001)("We must give the words of a statute their plain and ordinary meaning ....")(quoting *People v Morey*, 461 Mich 325, 329-30; 603 NW2d 250 (1999)); *Storey v Meijer, Inc*, 431 Mich 368, 376; 429 NW2d 169 (1988)("Legislative intent is to be derived from the actual language of the statute, and when the language is clear and unambiguous, no further interpretation is necessary.").

The judicial role "precludes imposing different policy choices than those selected by the Legislature." *The Herald Co v City of Bay City,* 463 Mich 111, 117; 614 NW2d 873 (2000). As this Court explained in *Hanson v Board of County Road Commissioners of the County of Mecosta,* 465 Mich 492, 504; 638 NW2d 396 (2002):

> [O]ur function is not to redetermine the Legislature's choice or to independently assess what would be most fair or just or best public policy.

Where the Legislature has not expressly defined common terms used in a statute, the Court may consider dictionary definitions to construe those words in accordance with their ordinary and generally accepted meanings. *In re Certified Question,* at 113. A word or phrase also derives meaning from its context or setting. *The Herald Co, supra* at 131 n.10.

B. To Effectuate the Plain Meaning of the Statute, the Word "Specialist" and "That Specialty" in the First Sentence of MCL 600.2169 (1)(a) and MCL 600.2169(1)(b)(i) Must be Construed to Encompass the Defendant's Actual Practice Specialty.

The first enacted version of MCL 600.2169 permitted the proffered expert to specialize and practice in an area of medicine that was "related" and "relevant" to the defendant's specialty. This meant that a specialist in one field could testify against a specialist in another field "as long as the two fields were connected to each other and had practical value to one another and as long as the proposed expert practiced or taught in the associated, pertinent area of health care." *McClellan v Collar,* 240 Mich App 403, 410; 613 NW2d 729 (2000).

The 1993 amendment eliminated this leeway by requiring that the expert specialize in the same specialty as the defendant.[15] "Same" quite clearly does not mean related or relevant.

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[15] A change in the language used in a statute is presumed to reflect a change in its meaning. *Michigan Millers Mutual Ins Co v West Detroit Building Co, Inc,* 196 Mich App 367, 373; 494 NW2d 1 (1992). Indeed, this Court has characterized the 1993 statute as "more restrictive" than the 1986 version. *McDougall v Schanz,* 461 Mich at 21, n2. Other Courts have reached the same conclusion. *See e.g., McClellan v Collar,* 240 Mich App at 408 n. 2 ("The 1993 amendments are

"Same" means identical. *See e.g., Oxford English Reference Dictionary* (Rev. 2d ed, 2002)(defining same to mean "... identical; not different; unchanged ..."); *Webster's Universal College Dictionary* (2001)(defining "same" as "identical with what is about to be or has just been mentioned ...") As plainly understood, a defendant who specializes in internal medicine and an expert whose specialty is the narrower field of infectious disease, which reflects more particularized training and a more focused practice than that of the defendant, do not specialize or devote a majority of their professional time to the "same" specialty. A contrary conclusion would turn the definition of "same" on its head.

Nothing in the commonly accepted meanings of "specialty" or "specialist" precludes attention to particularization. Indeed, particularity is the hallmark of specialization. In *Cox v Board of Hospital Managers for the City of Flint,* 467 Mich 1, 18-19, this Court quoted the *Random House Webster's College Dictionary* (1997), which defined specialist as "a medical practitioner who deals only with a particular class of diseases, conditions, patients, etc." *See also, Decker v Flood,* 248 Mich App 75, 83; 638 NW2d 163 (2001) (quoting same *Random House Webster's College Dictionary* (1997) definition, as well as the *Stedman's Medical Dictionary* (26th ed) definition which defines specialist as "one who devotes professional attention to a particular specialty or subject area.") A similar definition was employed in *Jalaba v Borovoy,* 206 Mich App 17, 22; 520 NW2d 349 (1994), where the Court of Appeals observed that a doctor is a specialist "on the basis of advanced training and expertise in a particular field of general medicine." *See also, Webster's New World College Dictionary* (4th ed,

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more restrictive than the requirements set out in the version of § 2169 that applies to this case"); *Shenduk v Harper Hospital,* 1999 Mich App LEXIS at *24 (1999)(Murphy J, concurring and dissenting)("the increased restriction of the current 1993 version, not allowing for specialists of a *related* discipline, indicates that strict adherence is intended.").

2002)("specialize" means "to make special, specific, or particular; specify ... to direct toward or concentrate on a specific end ... to make a special study of something or work only in one part or branch of a subject, profession, *etc* ..."); *Oxford English Reference Dictionary* (Rev. 2d ed, 2002)("specialist" means "... a person who specially or exclusively studies a subject or a particular branch of a subject ..."); *Merriam-Webster's Collegiate Dictionary* (11th ed 2004) ("specialize" means "to apply or direct to a specific end or use ... to concentrate one's efforts in a special activity, field, or practice ..."); *Webster's Universal College Dictionary* (2001) ("specialist" includes " ... a medical practitioner who deals only with a particular class of diseases, conditions, patients, etc. ... ")

These well-accepted definitions of "specialty," "specialist," and "specialize" are broad enough to encompass the more particularized training, qualifications, and practice areas which, although sometimes referred to as subspecialties, are in fact only narrower specialties. The statute does not expressly limit its scope to *primary* or *general* specialties or expressly exclude *narrower or more focused* specialties. This Court would have to read words into the statute to impose such a restriction. It would be illogical to do so. If, in the context of *Hamilton*, specialty is to be given no greater meaning than "internal medicine," nephrologists, oncologists, cardiologists, and gastroenterologists who are also board certified in internal medicine would be qualified to testify against Dr. Kuligowski. This is because *Hamilton* would consider each of these specialty practices to fall within the practice of internal medicine.

Giving "specialty" a meaning that includes sub-specialties is consistent with other legislative uses of the word. Section 16105(3) of Part 161 of the Public Health Code, which contains "General Provisions," defines a "health profession specialty field" as "an area of practice established under this article which is within the scope of activities, functions, and duties

of a licensed health profession and which requires advanced education and training beyond that required for initial licensure." MCL 333.16105(3). Nothing in this definition of "specialty field" distinguishes between specialties or sub-specialties or excludes sub-specialties from the intended meaning. In fact, sub-specialties fit neatly within the definition.

Part 27 of the Public Health Code pertains to "Michigan Essential Health Provider Recruitment Strategy." Sections 2705 and 2707 establish the terms upon which the health department may provide minority grants and tuition loan repayments for health professionals who agree to engage in the full-time practice in a health resource shortage area. MCL 333.2705, MCL 333.2707. Section 2711 requires the department to recruit "physicians qualified or students training to become qualified" in designated physician "specialty" areas and requires that the physicians be "board certified, or eligible for board certification" in those areas. MCL 333.2711. Section 2701(a) defines "board certified" to mean "certified to practice in a particular medical speciality [sic] by a national board recognized by the American Board of Medical Specialties or the American Osteopathic Association." MCL 333.2701(a). Although not expressly stated, the context implicitly encompasses sub-specialties because the American Board of Medical Specialties ("ABMS") and the American Osteopathic Association ("AOA") recognize boards that "certify to practice in a particular medical specialty" that might otherwise be considered a sub-specialty, such as cardiology, nephrology, and gastroenterology.

In related sections of Part 27, the department is authorized to develop criteria regarding "the average time the resident population must travel to obtain physician services from physicians in a designated physician specialty area" and to make recommendations concerning "physician specialty areas or other health professions for inclusion in the Michigan essential health provider recruitment strategy." MCL 333.2717(1)(i) and MCL 333.2723(b). Only by

artificial distinction could one logically conclude that these statutes do not allow recommendations and travel time criteria for sub-specialists, whose services may be as critically needed (and in even shorter supply) than more generalized specialists.

The context in which "specialize" is used in other legislative enactments leads to the same conclusion. In Section 498b of Chapter 4A of the Mental Health Code, which pertains to Civil Admission and Discharge Procedures for Emotionally Disturbed Minors, "child psychiatrist" is defined as "[a] psychiatrist who *specializes* in the evaluation and treatment of minors and is certified or eligible for certification as a child psychiatrist by the American board of psychiatry and neurology ..." or "[a] psychiatrist ... with educational and clinical experience in the evaluation and treatment of minors ..." MCL 330.1498b (emphasis added). This definition, although employing the word "specializes," clearly refers to a sub-specialty of psychiatry – child psychiatry.

Section 5815(a) of Part 58 of the Public Health Code applicable to "Crippled Children," requires the health department to establish and administer a program of services for crippled children and to "prescribe requirements for the approval of facilities and treatment centers, *medical and surgical specialists*, and other providers ..." MCL 333.5815(a) (emphasis added). Similarly, Section 5826 allows the department to approve *medical and surgical specialists* to render services. MCL 333.5826 (emphasis added). Because surgery is itself a specialty, "surgical specialists" can only refer to sub-specialties within the practice of surgery such as pediatric surgeons, orthopedic surgeons, neurosurgeons, and cardiac surgeons. Further, it would be illogical to prescribe requirements for "medical and surgical specialists" – such as pediatricians and general surgeons - but to have no requirements for sub-specialists, such as orthopedic surgeons or neurosurgeons.

Section 2617 of Part 26 (Data, Information, and Research) of the Public Health Code requires that a comprehensive health information system include statewide statistics relating to a variety of subjects including "[t]he utilization of health care, which may include the utilization of ambulatory health services by *specialties* and types of practices of the health professionals providing the services ..." MCL 333.2617(f) (emphasis added). Only a contorted interpretation of the word "specialty" would exclude from the survey the utilization statistics of sub-specialty fields like cardiology, nephrology, oncology, gastroenterology and the like.

Sub-specialties are also implicit in the Legislature's use of the word "specialist" in statutes outside the Public and Mental Health Codes. For example, MCL 791.244, which sets forth procedures for gubernatorial reprieves, commutation of sentences and pardons, provides that the office of health care shall evaluate the condition of a prisoner in all cases where a commutation application is based on physical or mental incapacity and if the office of health care confirms that a physical or mental incapacity exists, it "shall appoint a *specialist in the appropriate field of medicine* ... to evaluate the condition of the prisoner." MCL 791.244(c) (emphasis added). In this context, "the appropriate field of medicine" could well be cardiology if the prisoner suffers from heart disease, oncology if the physical incapacitation is cancer, nephrology if the prisoner suffers from kidney disease, or endocrinology if diabetes is the disabling cause. Nothing in the statute limits the specialist to be appointed under such circumstances to the umbrella specialty of internal medicine.

The same is true of uses of the word "specialist" and "specializes" in the Revised Judicature Act, of which the expert witness statute is a part. Enacted in 1986 along with the earlier version of the expert witness qualification statute, MCL 600.4905(1) requires that the health care provider members of medical malpractice mediation panels "specialize in the same or

a related, relevant area of health care as the defendant" if the defendant is a "specialist." Similarly, Section 401d of the Nonprofit Health Care Corporation Reform Act, MCL 550.1401d, provides reimbursement for services performed by a physician's assistant who works for a physician or facility that *specializes* in a particular area of medicine if the "physician that *specializes* in that area is physically present on the premises when the physician's assistant's services are performed." MCL 550.1401d(1)(a) (emphasis added). It would be illogical to exclude sub-specialty practice areas from the definition of "specializes" or "specialist" in either of these contexts. For example, it would be every bit as urgent – if not more so – to insure that a "nephrologist" is present when a physician's assistant performs nephrology services as it is to insure that an internal medicine specialist is present when the PA is performing services in the field of internal medicine. Similarly, the policy reasons that suggest the need for health care provider members of medical malpractice mediation panels to specialize in the same or a related, relevant field as the defendant, apply equally to defendants who are sub-specialists.

These statutes are compelling. Only a contorted, illogical interpretation would exclude sub-specialists from the meaning of "specialize" or "specialty" in any of these provisions – why then would the terms warrant a different definition in the expert witness context? When the same word or phrase is used in different parts of a statute, it is presumed to have the same meaning throughout. *See Phipps v Campbell, Wyant & Cannon Foundry,* 39 Mich App 199, 216; 197 NW2d 297 (1972). Although the above provisions are not part of the same statute, the same rule should apply. "Specialize" cannot mean one thing in some legislative enactments and another thing in others.

Thus, within the meaning of MCL 600.2169(1)(a) and (1)(b)(i), "specialize" and "that specialty" must include sub-specialties. An expert who specializes in infectious diseases cannot

articulate the standard of care applicable to a defendant who specializes in internal medicine. The Court of Appeals' holding to the contrary is error and should be reversed.[16]

C. "Active Clinical Practice" and "Active Clinical Practice of That Specialty," As Used in MCL 600.2169(1)(b)(i) Refers to the Defendant's Practice Specialty.

The expert witness statute not only requires that a standard of care expert be board certified in the same specialty as the defendant, it also requires that the expert have devoted, during the year immediately preceding the occurrence, a majority of his professional time to the active clinical practice of the defendant's *specialty*, or instruction in that *specialty*. As to this clinical practice requirement, MCL 600.2169(1)(b)(i) states:

> Subject to subdivision (c), during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:
>
> (i) The active clinical practice of the *same* health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of *that specialty*.

MCL 600.2169(1)(b)(i) (emphasis added). "That specialty" clearly refers to the preceding word "specialist." If the defendant is a specialist, the expert must have devoted a majority of his or her professional time to the active clinical practice of defendant's specialty. In this case, that specialty is internal medicine. By his own testimony, Dr. Markowitz cannot satisfy this requirement.

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[16] Courts have referred to the practice of infectious disease as a "specialty." *See e.g., Moy v Detroit Receiving Hospital,* 169 Mich App 600, 603; 426 NW2d 722 (1988)("infectious disease specialist"); *Ravenis v Detroit General Hospital*, 63 Mich App 9, 86; 234 NW2d 411 (1975)("specialist in infectious disease"); *Distefano v Michigan Womens Health Institute, P.C.*, 1999 WL 33433523, *1 (1999)(referring to experts as "specialists in infectious disease").

In *Woodard v Custer,* 2003 Mich App LEXIS 2647 (2003), *rev'd in part* 473 Mich 1; 701 NW2d 133 (2005), the Court of Appeals concluded that a pediatrician was not qualified to testify regarding the standard of care for a pediatric critical care specialist because he did not practice pediatric critical care medicine. The Court explained:

> Because the basis of the action is grounded in pediatric intensive care, plaintiffs were mandated by § 2169(1)(a) to present an expert who possessed that specialization. Dr. Casamassima's clinical practice during the year immediately preceding the instant injury, §2169(1)(b), did not involve pediatric critical care medicine. Given that Dr. Casamassima acknowledged that he was unaware of the precise standard of care for the treatment of critically ill infancts, it is clear that plaintiffs were required to present an expert witness who was.

Id. at *12.[17] *See also, Giusti v Mt. Clemens General Hospital,* 2003 Mich App LEXIS 3053 (2003) (Court of Appeals held that an expert whose testimony clearly and unequivocally demonstrated that he did not devote a majority of his professional time to the active clinical practice of emergency medicine for ten years preceding the date of the occurrence that gave rise to the action, was not qualified under the statute).

CONCLUSION AND RELIEF REQUESTED

The specialty differences between the defendant and his opposing expert are well-documented. In the serious business of medical malpractice litigation the Legislature has directed, as a matter of substantive law, that the specialties of the defendant and the expert be the "same" and that the expert devote a majority of his professional time to active clinical practice or instruction in that specialty. It remains for this Court to insure that the statute's requirements are properly enforced.

[17] This Court granted leave to appeal in this case. 471 Mich 890; 687 NW2d 298 (2004).

Amicus Curiae Michigan State Medical Society therefore joins Defendant-Appellant's request for relief and urges this Court to reverse the Court of Appeals' decision in *Hamilton v Kuligowski*.

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UNPUBLISHED CASES

LEXSEE 2003 MICH APP LEXIS 2647

JOHANNA WOODARD, Individually and as Next Friend of AUSTIN D. WOODARD, a Minor, and STEVEN WOODARD, Plaintiffs-Appellants, v JOSEPH R. CUSTER, M.D., Defendant-Appellee, and MICHAEL K. LIPSCOMB, M.D., MICHELLE M. NYPAVER, M.D., and MONA M. RISKALLA, M.D., Defendants. JOHANNA WOODARD, Individually and as Next Friend of AUSTIN D. WOODARD, a Minor, and STEVEN WOODARD, Plaintiffs-Appellants, v UNIVERSITY OF MICHIGAN MEDICAL CENTER, Defendant-Appellee.

No. 239868, No. 239869

COURT OF APPEALS OF MICHIGAN

2003 Mich. App. LEXIS 2647

October 21, 2003, Decided

NOTICE: [*1] THIS IS AN UNPUBLISHED OPINION. IN ACCORDANCE WITH MICHIGAN COURT OF APPEALS RULES, UNPUBLISHED OPINIONS ARE NOT PRECEDENTIALLY BINDING UNDER THE RULES OF STARE DECISIS.

SUBSEQUENT HISTORY: Later proceeding at *Woodard v. Custer, 471 Mich. 890, 687 N.W.2d 298, 2004 Mich. LEXIS 1902 (2004)*
Appeal granted by *Woodard v. Custer, 2005 Mich. LEXIS 1105* (Mich., July 12, 2005)
Reversed by, in part *Woodard v. Custer, 2005 Mich. LEXIS 1107* (Mich., July 12, 2005)

PRIOR HISTORY: Washtenaw Circuit Court Court of Claims. LC No. 99-005364-NH. LC No. 99-017432-CM. *Woodward v. Custer, 2003 Mich. App. LEXIS 2619* (Mich. Ct. App., Oct. 21, 2003)

JUDGES: Before: Meter, P.J., and Talbot and Borrello, JJ. BORRELLO, J., (dissenting). METER, J., (concurring in part and dissenting in part.)

OPINION: PER CURIAM.

In these consolidated medical malpractice cases against the physicians and the hospital who treated plaintiffs' infant son, plaintiffs appeal as of right from the trial court's order dismissing their medical malpractice claims with prejudice.

I. Facts and Procedural History

On January 30, 1997, plaintiffs' fifteen-day old infant son, Austin, was diagnosed with retrosyncytial virus bronchiolitis, a life-threatening respiratory disease that attacks infants, necessitating critical care treatment at the University of Michigan Medical Center's Pediatric Intensive Care Unit ("PICU") until February 10, 1997. The medical treatment included muscle relaxants and strong sedatives, mechanical ventilation and intubation, a feeding tube, and the placement of an arterial line in the femoral [*2] vein of the infant's right leg and a venous catheter inserted in the infant's left leg.

By February 10, 1997, the infant had made sufficient recovery that he was weaned from the sedatives and muscle relaxants. However, when he was moved from the intensive care unit to the general hospital ward, he became very agitated and he continuously cried. His left leg was purple in color and swollen as a result of the removal of the venous catheter from his left leg. An x-ray confirmed that deep vein thrombosis had developed in the left leg, a secondary condition to the venous catheter insertion. The x-ray also showed a fracture at the lower end of the femur in the infant's left leg. A subsequent skeletal survey revealed a fracture in the right leg, as well. The Medical Center's consultants were unable to determine the cause of the fractures.

In Docket No. 239868, plaintiffs filed suit against Dr. Joseph Custer, Director of the University of Michigan Medical Center's Pediatric Critical Care Medicine and the physicians who treated their son at the PICU. Plaintiffs raised claims of medical malpractice and negligent infliction of emotional distress. In Docket No. 239869, plaintiffs filed suit [*3] against the University of Michigan Medical Center, raising the same claims.

Dr. Custer and the other defendant physicians responded to the complaint in Docket No. 239868, by moving for summary disposition pursuant to *MCR*

2.116(4) (court lacks jurisdiction over subject matter), *MCR 2.116(5)* (lack of capacity to file suit in absence of an affidavit of merit), or *MCR 2.116 (7)* (the claim is barred for statutory reasons in the absence of an affidavit of merit). Dr. Custer and defendant physicians asserted that plaintiffs' affidavit of merit was untimely filed and that plaintiffs' medical expert, Anthony Casamassima, was not a qualified expert pursuant to *MCL 600.2169*, because he was not specialized in pediatric critical care or pediatric emergency medicine specialties as were Dr. Custer and defendant physicians.

At the time the trial court heard oral arguments for the motion, the two cases had been consolidated below. The court determined that the affidavit of merit signed by Dr. Casamassima was sufficient for the case to proceed but expressly stated on the record that it was not ruling on whether Dr. Casamassima was a qualified medical expert for purposes [*4] of trial testimony. The court informed defendants that they would be allowed to subsequently challenge Dr. Casamassima's qualifications as an expert witness.

All defendant physicians who treated the infant at the PICU were dismissed from the action by stipulation, leaving Dr. Custer and the Medical Center as the two remaining defendants in this case. After the two defendants deposed Dr. Casamassima, defendants filed four different motions. The Medical Center filed a motion for summary disposition pursuant to *MCR 2.116(C)(10)*, arguing that the testimony of plaintiffs' expert witness failed to support several claims against it because Dr. Casamassima did not provide the applicable standard of care and evidence of a breach of that standard. Dr. Custer filed a motion for summary disposition under *MCR 2.116(C)(10)*, on the ground that plaintiffs cannot bring suit against him under a negligent supervision or respondeat superior theory. Both defendants jointly moved for partial summary disposition pursuant to *MCR 2.116(C)(10)*, on the ground that plaintiffs' deposition testimony failed to support the claims of negligent infliction of emotional distress. Finally, both defendants jointly moved [*5] to strike Dr. Casamassima as an unqualified medical expert and to dismiss the case. In response to the above motions, plaintiffs asserted that the doctrine of res ipsa loquitur would allow an inference of negligence from the facts in this case. Specifically, plaintiffs argued that there was no need for an expert witness because an inference of negligence may be inferred from the fact that the infant was admitted to the PICU with healthy legs only to leave the PICU with fractured legs.

At the hearing for the above motions, defendants' counsel stated that the issue of the applicability of the doctrine of res ipsa loquitur should be reserved for an evidentiary hearing at a later date. Also at the hearing, plaintiffs agreed to dismiss the claims for negligent infliction of emotional distress. Following oral arguments, the trial court granted defendants' motion to strike plaintiffs' expert witness, ruling that Dr. Casamassima was not qualified as a medical expert under *MCL 600.2169*.

The scope of the trial court's decision at the hearing is unclear from the record and we cannot discern whether the court granted defendants summary disposition. Defendants appeared [*6] to have understood that the court did because they attempted to enter an order of dismissal. In response, plaintiffs objected to the entry of the order and they filed a motion for leave to file an amended complaint to assert negligence under the doctrine of res ipsa loquitur. Plaintiffs also filed a motion for a determination whether expert testimony was required in this case or, in the alternative, for leave to substitute their expert witness. In a written opinion and order following oral arguments, the court determined that the elements of the doctrine of res ipsa loquitur were not satisfied, that expert testimony was necessary because negligence could not be inferred from the facts, and that plaintiffs' request to substitute their expert was untimely. Accordingly, the court dismissed plaintiffs' case with prejudice, reasoning that without expert testimony plaintiffs could not prove their medical malpractice claims.

II. Standard of Review

It is unclear from the above-mentioned procedural history and from the written opinion and order dismissing the case whether the trial court determined the matter under defendants' motions for summary disposition pursuant to *MCR 2.116(C)(10)*, [*7] or as a result of an evidentiary hearing in which the court ruled to dismiss the case because plaintiffs failed to support their claims. The former would be reviewed under a de novo standard, *Spiek v Dep't of Transportation, 456 Mich. 331, 337; 572 N.W.2d 201 (1998)*, while the latter would be under an abuse of discretion standard. See *Vicencio v Ramirez, 211 Mich. App. 501, 506; 536 N.W.2d 280 (1995); Zantop Int'l Airlines, Inc v Eastern Airlines, 200 Mich. App. 344, 359; 503 N.W.2d 915 (1993)*.

The procedural history in this case indicates that plaintiffs' motion to amend its complaint to add the doctrine of res ipsa loquitur was unnecessary. Plaintiffs were not attempting to add new claims but only to assert the manner in which they were to prove their original claims. The doctrine was first raised in plaintiffs' response to the motions for summary disposition and it is unclear why it was not addressed at the hearing for the summary disposition motions when the necessary deposition testimony upon which plaintiffs relied was already before the trial court. The fact that the court did not address [*8] this argument at the hearing would suggest that it was obliged to do so as a continuation of its ruling on summary disposition. It is apparent that plaintiffs filed the

motion to amend their complaint in an effort to salvage the case from premature dismissal. Accordingly, the court's ruling was determined as part of the continuation of the hearing on defendants' motions for summary disposition.

Summary disposition is appropriate when there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. *Auto-Owners Ins Co v Allied Adjusters & Appraisers, Inc, 238 Mich. App. 394, 397; 605 N.W.2d 685 (1999).* In reviewing motions for summary disposition brought under *MCR 2.116(C)(10)*, this Court considers the pleadings, affidavits, depositions, and other documentary evidence submitted by the parties in the light most favorable to the party opposing the motion. *Tate v Detroit Receiving Hosp, 249 Mich. App. 212, 215; 642 N.W.2d 346 (2002).* Whether a witness is qualified to render an expert opinion and the actual admissibility of the expert's testimony are within the trial court's discretion [*9] and such determinations are reviewed on appeal for an abuse of discretion. *Id.* In civil cases, an abuse of discretion is found only in extreme cases in which the result is so palpably and grossly violative of fact and logic that it evidences a perversity of will, a defiance of judgment, or the exercise of passion or bias. *Dep't of Transportation v Randolph, 461 Mich. 757, 768; 610 N.W.2d 893 (2000).*

III. Analysis

A. Medical Expert Witness Qualifications

Plaintiffs argue that the trial court abused its discretion in determining that Dr. Casamassima was an unqualified medical expert. Specifically, plaintiffs claim that their theory of the case is not grounded in pediatric critical care but in general pediatric medicine, and that both Dr. Casamassima and Dr. Custer were board certified in pediatric medicine. Plaintiffs also assert that Dr. Custer's specialization in pediatric critical care was a "subspecialty" which Dr. Casamassima was not required to possess under *MCL 600.2169.*

In pertinent part, *MCL 600.2169* provides:

> (1) In an action alleging medical malpractice, a person shall not give [*10] expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. *However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.* [Emphasis added.]

Plaintiffs claim that the basis for the action is not grounded in pediatric critical care but in general pediatric medicine because the fractures were caused by "the manner in which the infant was handled and maneuvered" at the PICU. However, as further discussed in the second issue in this opinion, plaintiffs were unable to establish that the fractures were caused by the manner in which the infant was "handled and maneuvered" at the PICU. It was disputed whether the fractures occurred during the infant's stay [*11] at the PICU and whether the injuries resulted from a pathological cause or child abuse. Accordingly, plaintiff's claim that the fractures were caused by the mere "handling and maneuvering" of the infant during its stay at the PICU is without merit. n1

> n1 Plaintiffs argue that defendants failed to present evidence showing that the manner in which an infant should be "handled and maneuvered" is "unique" to critical care. However, it is the *plaintiff's* burden of proof to show the standard of care in a medical malpractice case. *Locke v Pachtman, 446 Mich. 216, 222; 521 N.W.2d 786 (1994).*

Moreover, plaintiffs have not established that the medical standard of care for an inpatient intensive care unit for critically ill infants is the same as that for general pediatric medicine. It appears from the record that it is not. Plaintiffs' own expert witness, Dr. Casamassima, testified that a number of procedures that were performed on the infant at the PICU had the potential to cause fractures [*12] to the legs. He did not assert that those procedures were normally practiced in general pediatrics or that the standard of care for the treatment of critically ill infants was the same as that for general pediatric practice. Rather, he opined that the standard of care for the PICU was grounded in the policies and procedures established for those medical procedures - but he expressly testified that he did not know what the policies and procedures were. Accordingly, plaintiffs' theory of the case was grounded not in general pediatric treatment but in pediatric intensive care.

Because the basis of the action is grounded in pediatric intensive care, plaintiffs were mandated by § 2169(1)(a) to present an expert who possessed that specialization. Dr. Casamassima's clinical practice during

the year immediately preceding the instant injury, § 2169(1)(b), did not involve pediatric critical care medicine. Given that Dr. Casamassima acknowledged that he was unaware of the precise standard of care for the treatment of critically ill infants, it is clear that plaintiffs were required to present an expert witness who was.

Plaintiffs rely on this Court's decision in *Tate, supra,* [*13] and argue that § 2169(1)(a) does not require Dr. Casamassima to possess the same "subspecialties" of pediatric critical care medicine and pediatric intensive care that Dr. Custer possessed. Plaintiffs misread the decision in *Tate*, which held:

> Thus, where a defendant physician has several board certifications and the alleged malpractice involves only one of these specialties, § 2169 requires an expert
>
> witness to possess the same specialty as that engaged in by the defendant physician during the course of the alleged malpractice. [*Tate, supra at 220.]*

Dr. Casamassima's testimony in this case was offered against Dr. Custer. It is undisputed that Dr. Custer was board certified in three specialty areas: pediatrics, pediatric critical care medicine, and neonatology-perinatology. Plaintiffs have provided nothing to establish that any of the three certifications was a "subspecialty." The decision in *Tate* mandates that, because plaintiffs' claims rested in the area of pediatric critical care medicine and because Dr. Custer was board certified in pediatric critical care medicine, plaintiffs' expert was required to posses that specialty. [*14] Insofar as the trial court determined that Dr. Casamassima was required to possess the same subspecialties as Dr. Custer and the physicians who treated the infant at the PICU, such ruling was erroneous, but harmless. Therefore, the trial court did not abuse its discretion when it determined that Dr. Casamassima did not meet the qualifications requirements set forth in § 2169(1)(a), because he did not possess board certification in pediatric critical care medicine.

B. Exceptions to Expert Witness Testimony

Plaintiffs next argue that the trial court erred in determining that the doctrine of res ipsa loquitur was inapplicable in this case.

To prove a medical malpractice claim, a plaintiff must establish the following four factors: (1) the applicable standard of care, (2) breach of that standard of care by the defendant, (3) injury, and (4) proximate causation between the alleged breach and the injury. *Locke v Pachtman, 446 Mich. 216, 222; 521 N.W.2d 786 (1994).* "In an action alleging medical malpractice, the plaintiff has the burden of proving that he or she suffered an injury that more probably than not was proximately caused by the negligence of the [*15] defendant or defendants." *MCL 600.2912a(2).* Expert testimony is required in medical malpractice cases to establish the applicable standard of care and to demonstrate that the defendant somehow breached that standard. *Birmingham v Vance, 204 Mich. App. 418, 421; 516 N.W.2d 95 (1994).* However, "while expert testimony is the traditional and the preferred method of proving medical malpractice, exceptions to the need for expert testimony have been recognized" and one such exception is when a plaintiff's case satisfies the doctrine of res ipsa loquitur. *Locke, supra at 230.* Where the elements of the doctrine are satisfied, negligence can be inferred. *Thomas v McPherson Community Health Center, 155 Mich. App. 700, 705; 400 N.W.2d 629 (1986).* The following four factors are necessary to a res ipsa loquitur claim:

> (1) the event must be of a kind which ordinarily does not occur in the absence of someone's negligence;
>
> (2) it must be caused by an agency or instrumentality within the exclusive control of the defendant;
>
> (3) it must not have been due to any voluntary [*16] action or contribution on the part of the plaintiff. . . .
>
> [4] "evidence of the true explanation of the event must be more readily accessible to the defendant than to the plaintiff." [*Locke, supra,* quoting *Jones v Porretta, 428 Mich. 132, 150-151; 405 N.W.2d 863 (1987).]*

As to the first factor, "the fact that the injury complained of does not ordinarily occur in the absence of negligence must either be supported by expert testimony

or must be within the common understanding of the jury." *Locke, supra at 231.*

The trial court determined that expert testimony was required in this case in order to address whether the fractures could have occurred in the absence of negligence and to rule out the possibility that the fractures were caused as risks arising from the types of procedures performed at the PICU. It is unfortunate that the cause of the fractures or an exact timeframe in which the fractures occurred were never determined in this case, particularly because it appears that Austin may face extensive medical treatment due to the resulting difference in the length of his legs. However, as the court [*17] concluded, plaintiffs' case cannot proceed without expert testimony which was necessary to establish that defendants actually caused an injury for purposes of the medical malpractice claim.

First, and contrary to plaintiffs' contention on appeal, it is disputed whether the fractures occurred during the infant's stay at the PICU. Plaintiffs rely on the deposition testimony of three adverse witnesses: in addition to Dr. Custer's testimony, plaintiffs rely on the testimony of Dr. Randall Loder, an orthopedic surgeon at the Medical Center, and Dr. Clyde Owings, the medical director of the Child Protection Team at the Medical Center, both of whom investigated the causes of the fractures at the time the fractures were discovered.

Dr. Loder opined that the fractures were inflicted. He concluded that the bone growth surrounding the fractures indicated that the fracture in the left leg occurred within seven days of the February 11, 1997, x-ray. This would place the injury during the infant's stay at the PICU. Dr. Loder also concluded that the fracture in the right leg occurred between fourteen to twenty-one days of the February 13, 1997 skeletal survey. This would place the injury's occurrence [*18] on the first day the infant was admitted to the PICU or any time during the preceding week or so. On the other hand, Dr. Owings concluded that the right leg was not fractured. Instead, he determined that the infant suffered from periosteal stripping in the right leg that can be pathologically caused in fifteen to thirty percent of the cases, and he doubted whether Dr. Loder was professionally capable of diagnosing this disease that was unrelated to the treatment of bones. Importantly, Dr. Owings opined that determining the age of fractures was similar to that of appraising art, and he did not rule out the possibility that the fracture in the left leg could have been caused at the time of the infant's birth.

Although Dr. Custer did not dispute the existence of the fractures, he never determined when the fractures occurred. Similar to Dr. Owings' determination, Dr. Custer did not rule out the possibility that the infant already had the fractures when he was admitted to hospital. Dr. Custer, who examined the infant upon admission, explained that he had personally missed diagnosing this specific type of fracture in the physical examination of infants and that a skeletal survey was the [*19] method used in such diagnosis. Dr. Loder supported the above testimony by explaining that it was difficult to discover this type of fracture through a physical examination because some infants simply do not cry to notify the examiner of anything that may be wrong. Dr. Owings also explained that the pain reaction of infants is considerably different than that of adults, and bone fractures of this sort were difficult to discover in an infant. Thus, even viewed in the light most favorable to plaintiffs, the testimony upon which they rely does not rule out the possibility that the fractures may have occurred before the infant was admitted to the hospital.

Second, the possibility of a pathological cause for the fractures was never ruled out by the witnesses upon whose testimony plaintiffs rely. While Dr. Custer testified that he could rule out the possibility of brittle bone disease from the record before him at the time of his deposition, he did not render an opinion with respect to any other type of pathological cause for the fractures. Dr. Owings discovered from his physical examination of the infant common forms of osteogenisis imperfecta, or brittle bone disease, but he left the proper [*20] diagnosis to the experts in the field. The record indicates that an expert in the field, a Dr. Innis, had examined the infant but it does not appear that he was deposed in this case. Dr. Loder agreed that Dr. Innis' examination of the infant at the time the fractures were discovered revealed no evidence of osteogenisis imperfecta, but he also added that osteogenisis imperfecta constituted a clinical diagnosis requiring the monitoring of the infant's growth. On this record, there is nothing to show that osteogenisis imperfecta or any other pathological cause were medically ruled out.

Third, and contrary to plaintiffs' assertion on appeal, an intentional injury under child abuse was also not ruled out in this case. Both Dr. Custer and Dr. Loder never formulated an opinion whether the fractures were caused as a result of child abuse. On the other hand, Dr. Owings did not find evidence sufficient to make a report for Child Protective Services, but he did not rule out the possibility of child abuse. It must be noted here that Dr. Owings also testified that, out of the hundreds of cases that he had investigated, this was the only one in which he had no record of his investigation. However, [*21] because Dr. Owings did not rule out child abuse as a cause for the fractures, plaintiffs' claim that child abuse was ruled out in this case is without merit.

Thus, given that plaintiffs failed to prove that the fractures actually occurred during the infant's stay at the

PICU, plaintiffs have failed to show that defendants caused the injuries or that the injuries were of a kind that ordinarily do not occur in the absence of someone's negligence to satisfy the first factor for the doctrine of res ipsa loquitur.

Plaintiffs also failed to show that the fractures were caused by an agency or instrumentality within the exclusive control of defendants to satisfy the second factor for the doctrine of res ipsa loquitur. Even assuming that the fractures occurred during the infant's stay at the PICU, the proofs established that persons other than medical staff had access to the infant, including his parents, grandmother, and the parent of the child with whom the infant shared a hospital room.

Because the fractures could have occurred before the infant's hospitalization and because plaintiffs had access to the infant during his stay at the PICU, plaintiffs also failed to satisfy the third factor, [*22] which provides that the injuries must not have been caused by any voluntary action or contribution on the part of plaintiffs. As to the fourth factor, the results of the Medical Center's extensive medical investigation into the matter, involving experts from at least three different medical fields, was inconclusive. From this record, it cannot be said that the evidence of the true explanation of the event was more readily accessible to defendants than to plaintiffs to satisfy the fourth factor. Therefore, the elements of the doctrine of res ipsa loquitur were not met in this case.

Plaintiffs next argue that an expert witness was not required because the alleged negligence was "a matter of common knowledge and observation." Expert testimony may not be required when "the lack of professional care is so manifest that it would be within the common knowledge and experience of the ordinary layman that the conduct was careless and not conformable to the standards of professional practice and care . . . ." *Locke, supra at 232.*

Assuming that the injuries were sustained during the infant's stay at the PICU, there is nothing whatsoever on this record to indicate that the fractures [*23] were caused by the manner in which the infant was handled and maneuvered, as plaintiffs claim. Therefore, any inference of malpractice must derive from the treatment that the infant received. Such treatment included muscle relaxants and strong sedatives, mechanical ventilation and intubation, a feeding tube, and the placement of an arterial line in the femoral vein of the infant's right leg and a venous catheter inserted in the infant's left leg. Accordingly, the trial court did not err in finding that the procedures the infant underwent were not within the common knowledge of a reasonably prudent factfinder. Assuming that the fractures may have been caused by the placement of the lines in the infant's legs, the risks associated with the placement of arterial lines or venous catheters in a newborn infant, and whether fractures ordinarily do not occur in the absence of negligence, are not within common knowledge of a reasonably prudent fact finder.

Plaintiffs' reliance on the decisions in *Sullivan v Russell, 417 Mich. 398; 338 N.W.2d 181 (1983),* and *Higdon v Carlebach, 348 Mich. 363; 83 N.W.2d 296 (1957)* is misplaced. In those [*24] cases, healthy and undiseased parts of the body requiring no treatment were injured. It appears that plaintiffs assume that the fractures were caused by the placement of the arterial line and venous catheter in the infant's legs. However, the infant's mother testified that the placements were made because the physicians could not locate the relevant veins in the infant's head. Plaintiffs do not dispute that such procedure was necessary for treating the life-threatening respiratory disease with which the infant was diagnosed. While the legs may have required no treatment, their use was necessary for the treatment of the diseased parts of the infant's body. Thus, the trial court properly ruled that the medical practice in this case was not a matter of common knowledge.

/s/ Michael J. Talbot

CONCURBY: Patrick M. Meter

CONCUR: METER, J. (*concurring in part and dissenting in part.*)

I concur with Judge Talbot's analysis of the expert witness issue. I concur with Judge Borrello's analysis of the res ipsa loquitur issue. I find moot the issue concerning the amended complaint because, given today's resolution of the res ipsa loquitur issue, the original complaint sufficiently contains [*25] the allegations necessary for plaintiffs to proceed with their claims. In other words, the doctrine of res ipsa loquitur merely provides plaintiff the means to prove the allegations in their original complaint.

Affirmed in part, reversed in part, and remanded for trial. We do not retain jurisdiction.

/s/ Patrick M. Meter

DISSENTBY: Stephen L. Borrello

DISSENT: BORRELLO, J. (*dissenting*).

I respectfully dissent from the opinion issued by Judge Talbot in this case.

Plaintiffs, on behalf of their minor son, brought an action for medical malpractice alleging that while their son Austin was in the care of defendants for retro-syncytial virus (RSV) bronchiolitis, he developed fractures in his right and left femurs. Plaintiffs pleaded that the negligence of defendants was based in part on defendants breaching the standard of care. Because their malpractice claims were initially based on this theory, plaintiffs produced an expert witness who was board certified in pediatrics. Defendant doctor in this case was board certified in pediatrics, pediatric critical care, and neonatology-perinatology. The trial court held that pursuant to *MCL 600.2169(1)(a)*, plaintiffs' [*26] expert was not qualified to testify.

Thereafter, defendants brought a motion pursuant to *MCR 2.116(C)(10)* stating that in the absence of an expert witness, plaintiffs' case must fail as a matter of law. The trial court granted defendants' motion to dismiss. Plaintiffs then brought a motion for leave to amend their complaint pursuant to *MCR 2.118(A)(2)*, claiming that the doctrine of res ipsa loquitur applied in this case. The trial court found that expert testimony was needed to prove res ipsa loquitur, and therefore, any amendment would be futile.

I conclude that the trial court abused its discretion in holding that plaintiffs' expert was not qualified to testify at trial pursuant to *MCL 600.2169(1)(a)*. I further find that no expert testimony was required under the doctrine of res ipsa loquitur as applied to the facts in this case.

Thus, I conclude that because the trial court premised its denial of its motion to amend on an erroneous determination that expert testimony was required, the trial court abused its discretion. I would therefore reverse and remand this matter to the trial court.

I. Issues Presented

The factual issue in this case [*27] concerns when and how Austin's femurs broke. Because the parties conceded at oral argument that there was no definitive evidence regarding how the injuries occurred, this case involves questions of fact that lie solely within the discretion of a jury. On appeal, plaintiffs present the following issues: was plaintiffs' expert qualified to testify, and is expert testimony necessary in a case where an infant is taken to a hospital for treatment of RSV bronchiolitis and somehow develops two broken femurs?

II. Plaintiffs' Expert Witness

In their initial complaint, plaintiffs alleged that defendants breached the standard of care owed to Austin by negligently placing a right arterial line and by leaving Austin lying on his left side too long after placing the left arterial line. Plaintiffs' expert witness was board certified in pediatrics. Defendant Custer was board certified in pediatrics, pediatric critical care, and neonatology-perinatology.

> *MCL 600.2169(1)* provides in relevant part:
>
> (1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person [*28] is licensed as a health professional in this state or another state and meets the following criteria:
>
> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.

In *Tate v Detroit Receiving Hosp, 249 Mich. App. 212; 642 N.W.2d 346 (2002)*, this Court held that whether a witness is qualified to serve as an expert witness is within the trial court's discretion, and the trial court's decision in that regard is reviewed for an abuse of discretion. *Id.* at 215. In civil cases, an abuse of discretion is found only in extreme cases where the result is so palpably and grossly violative of fact and logic that it evidences a perversity of will, a defiance of judgment, or the exercise of passion or bias. *Dep't of Transportation v Randolph, 461 Mich. 757, 768;* [*29] *610 N.W.2d 893 (2000); Spalding v Spalding, 355 Mich. 382, 384-385; 94 N.W.2d 810 (1959)*. Thus, the first inquiry is whether the trial court abused its discretion by striking plaintiffs' expert witness.

Plaintiffs contend that because the cause of action in this case centers on the broken femurs Austin allegedly incurred while in defendants' care, their expert was qualified to testify because all that was needed was an expert in general pediatric care. Plaintiffs' expert testified that Austin's fractures could have occurred when defendants positioned him during the insertion of a femoral venous line, a femoral arterial line, or peripheral intravenous lines; when they intubated him; or when they otherwise

maneuvered him. Some of these procedures were administered while Austin was in the pediatric intensive care unit at the University of Michigan hospital, and some were not. Both the time and the origin of the injuries are unanswered questions of fact.

Plaintiffs rely on this Court's statement in *Tate, supra,* that an expert's qualifications match every board certification that a defendant physician holds exactly. In *Tate*, we stated: [*30]

> Thus, where a defendant physician has several board certifications and the alleged malpractice involves only one of these specialties, § 2169 requires an expert to possess the same specialty as that engaged in by the defendant physician during the course of the alleged malpractice. [*Tate, supra at 220.*]

In this case, plaintiffs alleged that defendants committed malpractice when they improperly handled their child. Because nothing in the record requires the conclusion that the broken femurs occurred while defendants were practicing the specialty of intensive pediatric care, such a conclusion can only be reached through conjecture and speculation. The majority admits there is scant evidence regarding when the broken femurs occurred. In the absence of any direct proof regarding when the injury occurred, the trial court abused its discretion by concluding that an expert who was board certified in intensive pediatric care medicine was required.

Thus, I dissent because issues of fact should be decided by juries, not judges. To hold otherwise is to violate the Constitution's guarantee of a right to a trial by a jury. Thomas Jefferson understood that the litmus test [*31] of any democratic society was gauged by the degree to which citizens are given the opportunity of self-government. This meant not only the right to vote, the right to petition the government for redress, but also the right of the populace to sit as jurors. "I consider [trial by jury] as the only anchor ever yet imagined by man, by which a government can be held to the principles of its constitution." Thomas Jefferson to Thomas Paine, 1789. ME 7:408, Papers 15:269. "[The people] are not qualified to judge questions of *law,* but they are very capable of judging question of *fact.* In the form of juries, therefore, they determine all controverted matters of fact, *leaving thus as little as possible,* merely the law of the case, to the decision of the judges." Thomas Jefferson to Abbe Arnoux, 1789. ME 7:422, Papers 15:283 (emphasis added). For the trial court in this matter to have decided that the specialty in question was needed necessarily means that the trial court decided an issue of fact, thereby usurping the role of the jury.

III. Necessity of Expert Testimony under the Doctrine of Res Ipsa Loquitur

Our Courts have long harbored suspicion about the necessity [*32] of experts and their true value to juries. In 1874, our Supreme Court held in *People v Morrigan, 29 Mich. 4, 7 (1874),* that:

> The experience of courts with the testimony of experts has not been such as to impress them with the conviction that the scope of such proofs should be extended. Such testimony is not desirable in any case where the jury can get along without it; and is only admitted from necessity, and then only when it is likely to be of some value. [*Id.*]

Eighty years later, our Supreme Court in *Higdon v Carlebach, 348 Mich. 363, 374, 83 N.W.2d 296* n *; *83 N.W.2d 296 (1957),* commenting on the conclusion reached in *Morrigan, supra,* stated, "It is as true today as it was in 1874." Despite years of warnings from our Courts, our Legislature, by enacting *MCL 600.2169*, necessitated the use of expert witnesses in medical malpractice cases in all but a limited number of instances.

After the trial court dismissed this action, plaintiffs moved to amend their complaint to assert negligence under the doctrine of res ipsa loquitur. Plaintiffs also moved for a determination regarding whether [*33] expert testimony was required considering the facts that had been presented thus far. Plaintiffs argued that there was circumstantial evidence that entitled them to a presumption of negligence. Defendants argued that laypersons could not conclude that this type of injury could have occurred only from defendants' negligence, so expert testimony was necessary to establish that the femur fractures were the result of a breach of the standard of care concerning the manner in which an infant should be handled. The trial court concluded that expert testimony was needed, reasoning that the case involved "medical procedures and the application of those procedures, which information is not within the common knowledge and observation of a reasonably prudent jury." Therefore, citing futility, the court denied plaintiffs' motion to amend.

To prove a medical malpractice claim, a plaintiff must establish the following four factors: (1) the applicable standard of care, (2) breach of that standard of care by the defendant, (3) injury, and (4) proximate causation between the alleged breach and the injury. *Locke v Patchman, 446 Mich. 216, 222; 521 N.W.2d 786 (1994).* [*34] As a general rule, expert testimony is required in medical malpractice cases to establish the applicable standard of care and to demonstrate that the defendant somehow breached that standard. *Birmingham v Vance,*

204 Mich. App. 418, 421; 516 N.W.2d 95 (1994), citing *Bahr v Harper-Grace Hosps, 198 Mich. App. 31, 34; 497 N.W.2d 526 (1993).*

Nonetheless, there are two relevant exceptions to this rule:

> Where the negligence claimed is "a matter of common knowledge and observation," no expert testimony is required. *Daniel v McNamara, 10 Mich. App. 299, 308; 159 N.W.2d 339 (1968).* And, where the elements of the doctrine of res ipsa loquitur are satisfied, negligence can be inferred. *Neal v Friendship Manor Nursing Home, 113 Mich. App. 759; 318 N.W.2d 594 (1982). [Thomas v McPherson Center, 155 Mich. App. 700, 705; 400 N.W.2d 629 (1986).]*

Our Supreme Court in *Jones v Porretta, 428 Mich. 132, 150-151; 405 N.W.2d 863 (1987)* adopted the doctrine of res ipsa loquitur when it stated:

> Whether phrased as [*35] res ipsa loquitur or "circumstantial evidence of negligence," . . . it is clear that such concepts have long been accepted in this jurisdiction. The time has come to say so. We, therefore, acknowledge the Michigan version of res ipsa loquitur which entitles a plaintiff to a permissible inference of negligence from circumstantial evidence.
>
> The major purpose of the doctrine of res ipsa loquitur is to create at least an inference of negligence when the plaintiff is unable to prove the actual occurrence of a negligent act. According to Prosser & Keeton, Torts (5th ed), § 39, p 244, in order to avail themselves of the doctrine, plaintiffs in their cases in chief must meet the following conditions:
>
> (1) the event must be of a kind which ordinarily does not occur in the absence of someone's negligence; . . . .
>
> (2) it must be caused by an agency or instrumentality within the exclusive control of the defendant;
>
> (3) it must not have been due to any voluntary action or contribution on the part of the plaintiff. [*Id.*; see also *Wischmeyer v Schanz, 449 Mich. 469, 484 n 29; 536 N.W.2d 760 (1995).]*

Additionally, [*36] our courts have recognized that expert witnesses are not needed in cases where the lack of professional care is so manifest or egregious that a layman could determine the issue of negligence by resorting to common knowledge and experience. See *Roberts v Young, 369 Mich. 133, 138; 119 N.W.2d 627 (1963); Murphy v Sobel, 66 Mich. App. 122, 124; 238 N.W.2d 547 (1975); Burton v Smith, 34 Mich. App. 270, 272; 191 N.W.2d 77 (1971); Haase v DePree, 3 Mich. App. 337, 346; 142 N.W.2d 486 (1966).* For instance, where an instrument is left inside a patient after surgery, no expert testimony is required. *Taylor v Milton, 353 Mich. 421, 425-426; 92 N.W.2d 57 (1958);* see also *Higdon, supra at 374-376* (the defendant dentist drilled on a patient's tongue); *Winchester v Chabut, 321 Mich. 114, 119; 32 N.W.2d 358 (1948); LeFaive v Asselin, 262 Mich. 443, 446; 247 N.W. 911 (1933); Ballance v Dunnington, 241 Mich. 383, 387388; 217 NW 329 (1928)* (the plaintiff suffered [*37] severe burns due to X-ray over-exposure); *Loveland v Nelson, 235 Mich. 623, 624-625; 209 NW 835 (1926)* (the defendant dentist injected Lysol into a patient's gums, mistaking it for anesthetic); *Howard v Park, 37 Mich. App. 496, 502; 195 N.W.2d 39 (1972)* (the plaintiff suffered severe lacerations from a cutting wheel during removal of a leg cast).

In those cases, the courts determined that expert testimony was not a prerequisite to recovery because whether the acts in question were careless and not in accord with standards of good practice in the community was within the common knowledge and experience of the lay jurors. Likewise here, I find that where a child presented to the hospital for RSV bronchiolitis and developed two broken femurs, the doctrine of res ipsa loquitur applies and expert testimony is unnecessary.

Additionally, because we are bound to view the evidence in the light most favorable to the non-moving party, and because defendants presented no contrary evidence, the inference must be granted to plaintiffs that Austin's femurs were healthy at the time of admission. In fact, because Austin was undisputedly [*38] admitted to the hospital for treatment of RSV bronchiolitis and not for treatment of his legs, this case is analogous to the fact pattern set forth in *Higdon, supra.* In *Higdon, supra at 366-367,* a patient was having dentistry performed when the defendant's drill slipped and cut her tongue. Relying upon numerous cases from other jurisdictions, our Supreme Court held that a jury may infer negligence from

"lay proof" in cases where "healthy and undiseased parts of the body requiring no treatment are injured during the professional relationship, under circumstances where negligence may legitimately be inferred." *Id. at 374-376.*

In this case, Austin presented to the hospital to be treated for RSV bronchiolitis and subsequently sustained two broken femurs. A lay person can understand that RSV bronchiolitis is not connected to broken femurs and can infer negligence. Expert testimony is not necessary when an injury occurs to a healthy and undiseased body part that did not require treatment. *Higdon, supra at 374-376.* Viewing the evidence in the light most favorable to the nonmoving party, Austin's injuries were to parts of his body which [*39] at the time of admission we must infer were healthy and undiseased. I therefore find our Supreme Court's ruling in *Higdon* controlling. Accordingly, the trial court erred when it held that expert testimony was required.

IV.

Plaintiffs' Right to Amend Their Complaint

The last issue presented on appeal is whether the trial court erred when it denied plaintiffs' motion for leave to amend their complaint. Reviewing this issue for an abuse of discretion, *Dowerk v Oxford Charter Twp, 233 Mich. App. 62, 75; 592 N.W.2d 724 (1998),* I conclude that because the trial court erroneously held that expert testimony was required, it abused its discretion by denying plaintiffs' motion.

MCR 2.118(A)(2) provides that leave to amend a pleading "shall be freely given when justice so requires." Further, "if a trial court grants summary disposition pursuant to *MCR 2.116(C)(8)*, (C)(9), or (C)(10), the court must give the parties an opportunity to amend their pleadings pursuant to *MCR 2.118*, unless the amendment would be futile." *Doyle v Hutzel Hosp, 241 Mich. App. 206, 212; 615 N.W.2d 759 (2000).*

In this case, the trial court found that amendment [*40] would be futile because of an incorrect assertion that plaintiffs had to produce expert testimony to support their claims against defendants. In *Doyle, supra at 220,* this Court concluded that where a court's finding of futility is based on a faulty premise, the court's denial of the motion to amend the complaint constitutes an abuse of discretion. Having found that the trial court based its decision to deny plaintiffs the right to amend their complaint on a faulty premise, I would find that the trial court abused its discretion. I would therefore reverse the ruling of the trial court on all issues presented and remand this matter to the trial court for further proceedings in accordance with this decision.

/s/ Stephen L. Borrello

ROYAL MCQUIRE, Personal Representative of the Estate of MINNIE MCGUIRE, Plaintiff-Appellant, v HARRY J. WASVARY, M.D., Defendant-Appellee, and WILLIAM BEAUMONT HOSPITAL, Defendant.

No. 248309

COURT OF APPEALS OF MICHIGAN

2005 Mich. App. LEXIS 119

January 25, 2005, Decided

NOTICE: [*1] THIS IS AN UNPUBLISHED OPINION. IN ACCORDANCE WITH MICHIGAN COURT OF APPEALS RULES, UNPUBLISHED OPINIONS ARE NOT PRECEDENTIALLY BINDING UNDER THE RULES OF STARE DECISIS.

PRIOR HISTORY: Oakland Circuit Court. LC No. 2002-043598-NH.

DISPOSITION: Affirmed.

JUDGES: Before: Griffin, P.J., and Cavanagh and Fort Hood, JJ.

OPINION: PER CURIAM.

In this medical malpractice action, the defense challenged the qualifications of plaintiff's expert who, in an affidavit filed with the litigation, rendered an opinion regarding the standard of care and any breach. Specifically, defendant Dr. Wasvary asserted that he specialized in colon and rectal surgery at the time of the alleged malpractice. On the contrary, the expert provided by plaintiff was a general surgeon who did not practice in the same specialized area as defendant. Therefore, the defense moved for summary disposition of the complaint. The trial court concluded that the affidavit of merit did not comply with the statutory requirements, and there was no reasonable belief that plaintiff's expert was qualified to render an opinion. We affirm.

On September 6, 2002, plaintiff, the personal representative of the estate of decedent, filed a medical malpractice action, alleging [*2] that the decedent suffered from a bowel obstruction following a colonoscopy in December 1999. Despite the obstruction, plaintiff's decedent was released from the hospital, but was readmitted to the hospital after complaining of abdominal pain. Seven days later, the decedent died. In the complaint, it was alleged that defendant Dr. Wasvary and the general surgery residents of defendant hospital breached the standard of care by discharging her with the presence of the obstruction and failing to properly treat the obstruction, including but not limited to, prescribing the appropriate antibiotics, and failing to diagnose the obstruction. With the complaint, an affidavit of merit was filed by Chester Semel, M.D., indicating that he was a board certified general surgeon at the time of the alleged malpractice and was familiar with the standard of practice of a general surgeon and general surgery resident. The affidavit of merit contained the same alleged breaches of the standard of care delineated in the complaint.

On October 30, 2002, defendant moved for summary disposition. It was alleged that the affidavit filed by plaintiff was defective because Dr. Semel did not practice in the same [*3] specialty as defendant Dr. Wasvary. Furthermore, defendant asserted that he was a fellowship-trained colon and rectal surgeon. However, Dr. Semel was not a specialist in colon and rectal surgery and could only attest to the standard of care for general surgery. Therefore, defendant concluded that plaintiff had failed to comply with the statutory affidavit of merit requirement found in *MCL 600.2912d*, and dismissal was the appropriate remedy for the filing of a defective affidavit of merit.

Plaintiff opposed the motion for summary disposition, asserting that general surgery was a recognized specialty within the field of medicine, and defendant was a board certified general surgeon. n1 Therefore, plaintiff alleged that Dr. Semel, as a board certified general surgeon, was qualified to render an opinion regarding defendant's breach of the standard of care. Additionally, plaintiff alleged that defendant was not board certified in anything other than general surgery at the time of treatment. The trial court concluded that the statutory requirements were not satisfied when plaintiff's expert was a general surgeon whereas defendant was a colorectal surgeon. Additionally, [*4] the trial court concluded

that plaintiff could not have a reasonable belief that Dr. Semel was qualified to render an opinion when plaintiff's counsel had utilized Dr. Semel repeatedly in the past, and therefore, was aware of his qualifications and his expertise.

> n1 Although plaintiff's brief in opposition to the motion for summary disposition is not contained within the lower court file, plaintiff's position can be determined from the surreply brief and the brief on appeal.

Plaintiff asserts that the trial court erred in granting defendant's motion for summary disposition. We disagree. Issues of statutory construction present questions of law that are reviewed de novo. *Cruz v State Farm Mut Auto Ins Co, 466 Mich. 588, 594; 648 N.W.2d 591 (2002).* The goal of statutory construction is to discern and give effect to the intent of the Legislature by examining the most reliable evidence of its intent, the words of the statute. *Neal v Wilkes, 470 Mich. 661, 665; 685 N.W.2d 648 (2004).* [*5] If the statutory language is unambiguous, appellate courts presume that the Legislature intended the plainly expressed meaning and further judicial construction is neither permitted nor required. *DiBenedetto v West Shore Hosp, 461 Mich. 394, 402; 605 N.W.2d 300 (2000).*

Additionally, the rules addressing the propriety of summary disposition are also at issue in this appeal. We review summary disposition decisions de novo. *In re Capuzzi Estate, 470 Mich. 399, 402; 684 N.W.2d 677 (2004).* The moving party has the initial burden to support its claim to summary disposition by affidavits, depositions, admissions, or other documentary evidence. *Quinto v Cross & Peters Co, 451 Mich. 358, 362; 547 N.W.2d 314 (1996).* The burden then shifts to the nonmoving party to demonstrate a genuine issue of disputed fact exists for trial. *Id.* To meet this burden, the nonmoving party must present documentary evidence establishing the existence of a material fact, and the motion is properly granted if this burden is not satisfied. *Id.* Affidavits, depositions, and documentary evidence offered in support of and [*6] in opposition to a dispositive motion shall be considered only to the extent that the content or substance would be admissible as evidence. *Maiden v Rozwood, 461 Mich. 109, 118; 597 N.W.2d 817 (1999).*

MCL 600.2912d(1) provides, in pertinent part:

> Subject to subsection (2), n2 the plaintiff in an action alleging medical malpractice or, if the plaintiff is represented by an attorney, the plaintiff's attorney shall file with the complaint an affidavit of merit signed by a health professional who the plaintiff's attorney reasonably believes meets the requirements for an expert witness under [*MCL 600.2169*].

> n2 Subsection (2) of the statute addresses a motion for an extension of time to file the affidavit of merit where good cause is shown and is not at issue on appeal.

MCL 600.2169 addresses the qualifications of an expert witness in a medical malpractice action and provides, in relevant part: [*7]

> (1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.

In *Halloran v Bhan, 470 Mich. 572, 575; 683 N.W.2d 129 (2004),* the defendant physician treated the plaintiff's decedent. The defendant was board-certified in internal medicine, but also held a certificate of added qualification in critical care medicine. Both certifications were obtained from the American Board of Internal Medicine (ABIM). The parties did not dispute that the certificate of added qualification was not governed by the [*8] board certification requirements of the medical malpractice statute. *Id.*

The plaintiff presented an expert who was not board-certified in internal medicine. Rather, the plaintiff presented an expert who was board certified in anesthesiology by the American Board of Anesthesiology (ABA). However, the plaintiff's expert also received a certificate of added qualification in critical care medicine from the ABA. The plaintiff's expert was not board certified in

internal medicine nor did he have the applicable training that would make him eligible for internal medicine certification. Because the board certifications did not match, the defendant physician moved to strike the plaintiff's expert, and the circuit court agreed. The Court of Appeals reversed, concluding that the expert fell within the statutory requirements where the subspecialty of critical care was shared by both physicians. *Id.* at 575-576 .

The Supreme Court reversed the holding of the Court of Appeals, stating:

> We must now determine whether *MCL 600.2169(1)(a)* requires that an expert witness share the same board certification as the party against whom or on whose behalf the testimony [*9] is offered. We hold that it does.
>
> The Court of Appeals majority held that it is sufficient under the statute if the expert witness and the defendant doctor share only the same subspecialty, but not the same board certification. We disagree because this argument runs contrary to the plain language of the statute.
>
> This interpretation is supported by the use of the word "however" to begin the second sentence. Undefined statutory terms must be given their plain and ordinary meanings, and it is proper to consult a dictionary for definitions. *Donajkowski v Alpena Power Co, 460 Mich. 243, 248-249; 596 N.W.2d 574 (1999); Koontz v Ameritech Services, Inc, 466 Mich. 304, 312; 645 N.W.2d 34 (2002). Random House Webster's College Dictionary* (2d ed) defines "however" as "in spite of that" and "on the other hand." Applying this definition to the statutory language compels the conclusion that the second sentence imposes an *additional* requirement for expert witness testimony, not an optional one. In other words, "in spite of" the specialty requirement in the first sentence, the witness must also share the same [*10] board certification as the party against whom or on whose behalf the testimony is offered.
>
> There is no exception to the requirements of the statute and neither the Court of Appeals nor this Court has any authority to impose one. As we have invariably stated, the argument that enforcing the Legislature's plain language will lead to unwise policy implications is for the Legislature to review and decide, not this Court. See *Jones v Dep't of Corrections, 468 Mich. 646, 655; 664 N.W.2d 717 (2003).*
>
> It is not disputed that defendant Bhan is board certified in internal medicine, but proposed expert witness Gallagher is not. *MCL 600.2169(1)(a)* requires that the expert witness "must be" a specialist who is board certified in the specialty in which the defendant physician is also board certified. Because the proposed witness in this case is not board certified in the same specialty as Bhan, *MCL 600.2169(1)(a)* prohibits him from testifying regarding the standard of care. [*Id.* at 577-579 (footnotes omitted).]

In the present case, defendant filed an affidavit delineating his education [*11] and experience. Defendant graduated from Wayne State University School of Medicine in 1992, and followed his graduation with a residency in general surgery in 1998, and a fellowship in colon and rectal surgery in 1998-1999. In December 1999, defendant exclusively practiced in the area of colon and rectal surgery, an area he categorized as a distinct sub-specialty of general surgery. At the time of the alleged malpractice, defendant was board *eligible* for certification by the American Board of Colon and Rectal Surgeons and had since obtained his board certification in this specialty. Defendant opined that surgeons who wished to practice in the area of colon and rectal surgery were "typically" required to be specialists trained in the area of colon and rectal surgery. Defendant reviewed the affidavit and qualifications presented by plaintiff's expert. Based on this evaluation, Dr. Semel was not trained in the area of colon or rectal surgery and was not a member of the American Board of Colon and Rectal Surgeons.

Plaintiff did not file an affidavit from Dr. Semel to counter the attestations by defendant in his affidavit. Rather, the only affidavit filed by Dr. Semel was the affidavit [*12] of merit filed with the complaint. This affidavit merely concluded that Dr. Semel was a board certified general surgeon in 1999, and was familiar with the standard of practice for a general surgeon. The affidavit did not delineate whether Dr. Semel had any experience in the area of colon and rectal surgery.

Plaintiff alleges that because both surgeons were board certified in general surgery at the time of the alleged malpractice, the requirements of *MCL 600.2169* are satisfied. We disagree. Again, the key portion of the statute at issue provides:

> (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.

As stated by the *Halloran* Court, *MCL 600.2169(1)(a)* delineates *two* requirements for qualification of an expert [*13] witness in a medical malpractice case. With regard to the first requirement, the physicians are compared to determine if the physician is a specialist in a particular area. Where the subject of the litigation surrounds the actions of a specialist, that testimony must be countered with the testimony of an individual in the same specialty. *MCL 600.2169(1)(a)*; *Halloran supra* at 578-579. Then, if it is determined that the testimony is offered against a board certified specialist, n3 the testimony offered by a witness must share the same board certification. *Id.*

> n3 We note that this additional requirement is premised upon a contingency. It is invoked *if* a board certified specialist is involved. See e.g., *ISB Sales Co v Dave's Cakes, 258 Mich. App. 520, 529; 672 N.W.2d 181 (2003).*

Here, plaintiff's expert Dr. Semel has merely addressed the fact that both surgeons were board certified general surgeons at the time of the alleged malpractice. Plaintiff [*14] has failed to acknowledge the first requirement of the statute wherein it addresses whether testimony is offered against a specialist. Here, defendant has attested that he was a specialist in the area of colon and rectal surgery, regardless of the status of his board certification at the time of the alleged malpractice. Plaintiff failed to counter this documentary evidence with an affidavit from a specialist in colon and rectal surgery. *Halloran, supra; Maiden, supra.* Plaintiff failed to present any documentation to counter the contention that colon and rectal surgery was a specialty area of general surgery and failed to delineate the qualifications and experience of Dr. Semel in this area. n4 Accordingly, the trial court properly concluded that plaintiff failed to satisfy the requirements of *MCL 600.2169(1)(a). Halloran, supra.*

> n4 We note that plaintiff cites *Watts v Canady, 253 Mich. App. 468; 655 N.W.2d 784 (2002),* for the proposition that there are distinctions between specialist and subspecialists, and that defendant's colon and rectal surgery constitutes a subspecialty of general surgery. However, the *Watts* Court did not reach the issue of whether a subspecialty was encompassed within a specialty for purposes of *MCL 600.2169.* Rather, the *Watts* Court merely held that the plaintiff's attorney had a reasonable belief that the expert was qualified. *Id.* at 471-472. Moreover, we note that *MCL 600.2169* does not define or distinguish between specialist and subspecialists. However, the dictionary defines "specialist" as "a person devoted to one subject or to one particular branch of a subject or pursuit." *Random House Webster's College Dictionary* (2d ed), p 1260. Applying this definition to the statutory language, *Halloran, supra,* reveals that there is no such distinction where a specialist is devoted to a subject or a particular branch within a subject. Accordingly, this attempted distinction is without merit.

[*15]

Plaintiff nonetheless contends that there was a reasonable belief that Dr. Semel satisfied the requirements of *MCL 600.2912d.* We disagree. In *Grossman v Brown, 470 Mich. 593, 595-596; 685 N.W.2d 198 (2004),* the defendant performed surgery on plaintiff's decedent. The defendant was board certified in the area of general surgery and also held a "certificate of special qualifications in vascular surgery." In preparation for litigation, the plaintiff's counsel researched the qualifications of defendant to obtain a qualified expert witness to satisfy the affidavit of merit requirement, *MCL 600.2912d.* The American Medical Association (AMA) website was searched where the defendant's qualifications indicated that he was board certified only in general surgery. There was no indication that the defendant held any board certification in vascular surgery. Based on this research, the plaintiff's counsel obtained an affidavit of merit from a physician board certified in general surgery, but who also specialized in vascular surgery. The defendant filed a motion for summary disposition, and the trial court denied [*16] the motion, concluding that the plaintiff's attorney had a reasonable belief that his expert satisfied the statutory prerequisites for an expert witness. *Id.* at 596-597.

The Supreme Court affirmed the trial court's denial of the dispositive motion, holding:

> Because this case presents a dispute involving the affidavit-of-merit stage, the issue before us is whether, according to *MCL 600.2912d(1)*, plaintiff's attorney had a "reasonable belief" that his expert satisfied the requirements of *MCL 600.2169*. We hold that given the information available to plaintiff's attorney when he was preparing the affidavit of merit, he had a reasonable belief that Drs. Brown and Zakharia were both board-certified in their specialty of general surgery and that there was no board certification in vascular surgery.
>
> The salient and dispositive facts are that plaintiff's attorney consulted the AMA website, which supplied him with information that defendant Brown was only board-certified in general surgery and that there is no vascular surgery board certification. Further, counsel consulted Dr. Zakharia, his expert, who reiterated that [*17] there is no vascular surgery board certification.
>
> Thus, at the moment the affidavit of merit was being prepared, plaintiff's attorney used the resources available to him and reasonably concluded that he had a match sufficient to meet the requirements for naming an expert. It may be that what satisfied the standard at this first stage will not satisfy the requirements of *MCL 600.2169* for expert testimony at trial. This will be decided on remand. To address this matter now, especially because there has been no fact-finding on the disputed factual questions, would be premature. It will be for the trial court, in its role as initial interpreter of the statute and qualifier of experts, to decide this issues as they become timely. [*Id.* at 599-600 (footnotes omitted).]

In the present case, plaintiff asserts that the reasonable belief requirement of *MCL 600.2912d* is satisfied because defendant was a general surgeon at the time of the alleged malpractice and an affidavit was obtained from a general surgeon. In the narrative portion of the brief, plaintiff's counsel asserts that the qualifications of the two surgeons were [*18] matched prior to the filing of the litigation and only discovery would have revealed that defendant was practicing in a subspecialty at the time of the malpractice. This blanket assertion is insufficient to oppose the motion for summary disposition. *Maiden, supra.* Plaintiff's counsel fails to delineate whether there was ever any research into the qualifications of defendant Dr. Wasvary and whether there was any attempt to match those qualifications with an expert for the purposes of filing an affidavit of merit with the complaint. n5 Accordingly, the trial court did not err in granting defendant's motion for summary disposition.

> n5 Defendant attached deposition testimony from plaintiff's expert filed in other litigation. There is no indication that plaintiff's expert had performed any surgery within the area of expertise held by defendant. Plaintiff fails to delineate whether the qualifications and any experience in colon and rectal surgery by Dr. Semel was questioned by counsel.

Affirmed. [*19]

/s/ Richard Allen Griffin

/s/ Mark J. Cavanagh

/s/ Karen M. Fort Hood

1 of 1 DOCUMENT

SYLVIA DISTEFANO, as Independent Personal Representative of the Estate of BABY GIRL DISTEFANO, Deceased, and SYLVIA DISTEFANO and JOHN DISTEFANO, Individually, Plaintiffs-Appellees, v MICHIGAN WOMENS HEALTH INSTITUTE, P.C., d/b/a MICHIGAN WOMENS HEALTH INSTITUTE, and LAWRENCE B. PRUSSACK, M.D., Defendants-Appellants.

No. 204787

COURT OF APPEALS OF MICHIGAN

1999 Mich. App. LEXIS 2544

October 26, 1999, Decided

NOTICE: [*1] IN ACCORDANCE WITH THE MICHIGAN COURT OF APPEALS RULES, UNPUBLISHED OPINIONS ARE NOT PRECEDENTIALLY BINDING UNDER THE RULES OF STARE DECISIS.

PRIOR HISTORY: Oakland Circuit Court. LC No. 95-496139 NH.

DISPOSITION: Affirmed.

JUDGES: Before: Hoekstra, P.J., and O'Connell and R. J. Danhof *, JJ. Peter D. O'Connell, J., dissenting.

* Former Court of Appeals judge, sitting on the Court of Appeals by assignment.

OPINION: PER CURIAM.

Following a trial of plaintiffs' medical malpractice claims, a jury returned a verdict for plaintiffs totaling $ 225,000. Defendants appeal by right, arguing that the trial court erred in allowing plaintiffs' expert witness to testify despite the witness' lack of board certification in the same area as defendant Dr. Lawrence Prussack. The trial court's decision to admit the testimony under MCR 702 was based in part on this Court's decision in *McDougall v Eliuk, 218 Mich App 501; 554 NW2d 56 (1996),* which held that *MCLA 600.2169*; MSA 27A.2169 was unconstitutional. That statute required that expert witnesses in medical malpractice cases be board certified in the same area as the defendant physician, if that expert [*2] witness was going to testify as to the appropriate standard of care. Here, the witness in question was not board certified in the same area as defendant Dr. Lawrence Prussack. Since the parties filed their briefs in this case, our Supreme Court has reversed this Court's decision. See *McDougall v Schanz, 461 Mich. 15; 597 N.W.2d 148 (1999)* (finding that *MCLA 600.2169*; MSA 27A.2169 is constitutional). Consequently, the trial court erred under the statute in allowing the expert witness to testify as to the standard of care. Given that our Supreme Court has resolved the issue of whether the trial court erred, we are left to determine whether the error requires reversal. Because we find, after reviewing the peculiar circumstances of this case, that the error was harmless, we affirm.

While pregnant, plaintiff Sylvia Distefano contracted a bacterial infection known as Group A streptococcus, which caused the premature delivery and death of her daughter. At trial, plaintiffs argued that Sylvia had told Dr. Prussack, her obstetrician, that she was suffering from a fever of 103 degrees at various points in the days leading up to the miscarriage. [*3] Defendants deny that Sylvia reported such a high fever. Neither party, however, disputes that Dr. Prussack ordered a complete blood count (CBC) for Sylvia. The CBC results showed a slightly elevated white blood count and a "left shift." n1 Ultimately, Sylvia was admitted to the hospital with a temperature in excess of 105 degrees, where doctors diagnosed her as suffering from a bacterial infection and started her on antibiotics. Shortly after her admission, she lost her baby. In addition to the miscarriage, Sylvia became gravely ill from the infection, although she eventually recovered. Plaintiffs argue that had Dr. Prussack complied with the applicable standard of care, he would have diagnosed a bacterial infection and begun treatment in time to save Sylvia's baby.

n1 According to the record, a left shift is an increased percentage of neutrophils, particularly immature neutrophils.

On appeal, defendants' arguments center on the fact that the trial court allowed a specialist in infectious diseases, Dr. Gary Simon, [*4] to provide expert testimony regarding the appropriate standard of care for Dr. Prussack, a board certified OB/GYN. n2 We are mindful that, at the time the trial court rendered its decision, *MCL 600.2169*; MSA 27A.2169 had been declared unconstitutional. Nonetheless, the Supreme Court has recently stated "that *MCL 600.2169*; 27A.2169 is an enactment of substantive law" and "it does not impermissibly infringe [the Supreme Court's] constitutional rulemaking authority over 'practice and procedure.'" *McDougal v Schanz, supra,* slip op p 25. Consequently, because Dr. Simon was not a board certified OB/GYN, he was not qualified, under *MCL 600.2169(1)*; MSA 27A.2169(1), to give standard of care testimony in this case.

n2 Defendants also argue that Dr. Simon was not qualified to testify under MRE 702, an argument we reject. We review a trial court's determination that an expert witness is qualified for an abuse of discretion. *Bahr v Harper-Grace Hosp, 448 Mich 135, 141; 528 NW2d 170 (1995).* Given Dr. Simon's testimony that he was familiar with the standard of care applicable for obstetricians diagnosing an infection in a pregnant patient on the basis of his own education and practice, and from teaching medicine, the trial court cannot be said to have abused its discretion by determining, pursuant to MRE 702, that Dr. Simon was qualified to give standard of care testimony under the circumstances of this case. *Bahr, supra at 141-142.*

[*5]

We must determine what relief, if any, this error requires. This case is peculiar insofar as the trial court's ruling was correct at the time it was made but was rendered incorrect by our Supreme Court's subsequent ruling. Although there was clearly error here, nothing in *McDougall v Schanz, supra,* precludes application of the harmless error analysis in this sort of case. Indeed, according to MRE 103, error may not be predicated on a ruling which admits evidence unless a substantial right of the party is affected. Further,

> an error in the admission of evidence is not a ground for vacating, modifying, or otherwise disturbing a judgment unless refusal to do so would be inconsistent with substantial justice. [*Davidson v Bugbee, 227 Mich App 264, 266; 575 NW2d 574 (1997).]*

See also *Merrow v Bofferding, 458 Mich 617, 634; 581 NW2d 696 (1998).*

Here, we find the error was harmless, because it was not inconsistent with substantial justice. Plaintiffs offered the testimony of another expert, Dr. Sweet, who *was* a board certified OB/GYN and whose testimony substantially coincided with that of [*6] Dr. Simon. The only difference was that Dr. Sweet's opinion that Dr. Prussack breached the standard of care relied on the presumption that Sylvia told Dr. Prussack that her fever had been going as high as 103 degrees, while Dr. Simon opined that the failure to appreciate the CBC results alone was sufficient. We note that plaintiff did not advance Dr. Simon's theory as an alternative basis for liability. In fact, defendant has not shown a single point in the record where plaintiff questioned Dr. Simon about the possibility of finding liability based solely on the blood test. Plaintiffs maintained, from their opening statement through their closing argument, that Dr. Prussack should have diagnosed the infection based on both the fever and the CBC test results. Defendant appears to have elicited Dr. Simon's theory in an effort to show that the witnesses could not agree on what constituted the appropriate standard of care. In other words, it was a trial strategy designed to highlight a potential inconsistency between plaintiff's expert witnesses, a strategy which apparently backfired. n3

n3 Plaintiffs assert the time-honored rule that reversible error cannot be error to which the aggrieved party contributed by plan or negligence. See *Phinney v Perlmutter, 222 Mich App 513, 558; 564 NW2d 532 (1997).* Defendants respond that they were simply exploring the boundaries of the witnesses' theories and that they did not introduce the error at issue. While we certainly agree that defendant was entitled to explore the witnesses testimony, we cannot agree that they are entitled to claim prejudice based on testimony they elicited.

The dissent would hold that this error was harmful and prejudicial. In reaching that conclusion, however, the dissent places no weight on the fact that this testimony only entered through defendant's questioning, a point we find important to the analysis here.

[*7]

Further, we find it significant to our analysis here that defendants also produced two infectious disease specialists of their own, Dr. Zervos n4 and Dr. Lekas, both of whom opined that Dr. Prussack complied with the standard of care. Moreover, the bulk of the testimony by all of the infectious disease specialists addressed causation. Consequently, almost all of the testimony introduced at trial was proper, but Dr. Simon should not have been allowed to testify that Dr. Prussack breached the standard of care, and Dr. Zervos and Dr. Lekas should not have been allowed to testify that Dr. Prussack complied with it. Under these circumstances, we find no substantial injustice requiring reversal.

n4 Arguably, Dr. Zervos, was a fact witness. Nonetheless, he offered what was essentially expert witness testimony regarding the standard of care.

Affirmed.

/s/ Joel P. Hoekstra

/s/ Robert J. Danhof

DISSENTBY: Peter D. O'Connell

DISSENT: O'CONNELL, J. (dissenting).

I respectfully dissent. The majority concludes that it was error [*8] for the trial court to admit the expert testimony of a witness who was not qualified under *MCL 600.2169(1)*; MSA 27A.2169(1), this error was harmless. Unlike the majority, I cannot conclude that this error was harmless.

The majority notes that this case is "peculiar" in that the trial court was relying on *McDougall v Eliuk, 218 Mich App 501; 554 NW2d 56 (1994),* which was reversed after the trial court's ruling. See *McDougall v Schanz, 461 Mich 15; 597 NW2d 148 (1999).* However, this is irrelevant in determining whether the error was harmless. I would conclude that the error was not harmless because it was critical to the outcome of the case; therefore, to refuse to reverse is inconsistent with substantial justice. MRE 103(a); *Hurt v Michael's Food Center, Inc, 220 Mich App 169, 177; 559 NW2d 660 (1996).*

In this case, three out of the four expert witnesses who testified regarding the standard of care were not qualified under the statute and should not have been allowed to testify. Not only was one of plaintiff's expert witnesses not qualified, but both of defendant's [*9] expert witnesses were also not qualified. Additionally, the testimony of plaintiff's experts differed in one important respect--one of the experts testified that Dr. Prussack violated the standard of care solely on the basis of his misreading of results from a blood test, while the other expert testified that it was the blood-test results and the presence of a fever that should have alerted Dr. Prussack to the infection. Although plaintiffs did not present alternative theories of liability, whether Sylvia Distefano reported the fever to Dr. Prussack was disputed at trial. The majority notes that "almost all of the testimony introduced at trial was proper," but that three out of the four expert witnesses testifying to the standard of care should not have been allowed to testify. I cannot conclude that, where seventy-five percent of the expert testimony should not have been allowed, the evidentiary error was harmless. Accordingly, I would reverse and remand for a new trial.

/s/ Peter D. O'Connell

1 of 1 DOCUMENT

GARY E. GIUSTI, Plaintiff-Appellant, and BLUE CROSS & BLUE SHIELD OF MICHIGAN, Intervening Plaintiff, v MT. CLEMENS GENERAL HOSPITAL, Defendant-Appellee, and JAMES LARKIN, D.O., JAY KANER, D.O., and TRI-COUNTY NEUROLOGICAL ASSOCIATES, P.C., Defendants.

No. 241714

COURT OF APPEALS OF MICHIGAN

2003 Mich. App. LEXIS 3053

December 2, 2003, Decided

NOTICE: [*1] THIS IS AN UNPUBLISHED OPINION. IN ACCORDANCE WITH MICHIGAN COURT OF APPEALS RULES, UNPUBLISHED OPINIONS ARE NOT PRECEDENTIALLY BINDING UNDER THE RULES OF STARE DECISIS.

PRIOR HISTORY: Macomb Circuit Court. LC No. 1999-003849-NH.

DISPOSITION: Affirmed.

JUDGES: Before: Schuette, P.J., and Cavanagh and White, JJ. WHITE, J. (concurring in part and dissenting in part).

OPINION: PER CURIAM.

Plaintiff appeals as of right the trial court's grant of summary disposition in this medical malpractice action. We affirm.

On September 14, 1999, plaintiff commenced this action alleging that as a result of negligence, malpractice, and willful and wanton misconduct with regard to the medical treatment he received in 1997 following presentations to the emergency room, during a hospital admission, and during post-hospitalization visits, he suffered severe injuries. The defendants were Mt. Clemens General Hospital (MCGH), an emergency room physician at MCGH, Dr. James Larkin, a neurologist at MCGH, Dr. Jay Kaner, and Tri-County Neurological Associates, P.C. The affidavit of merit was signed by Alexander Mauskop, M.D., a purported expert in neurology. A second affidavit of merit was subsequently filed that was signed by Frank J. Baker, [*2] II, M.D., a purported expert in emergency medicine. On March 7, 2001, Dr. Larkin was dismissed as a defendant by stipulation.

On February 25, 2002, MCGH filed a motion for summary disposition, pursuant to *MCR 2.116(C)(8)* and (C)(10), arguing that (1) it could not be vicariously liable for Dr. Kaner's actions because Dr. Kaner had "a separate and distinct physician-patient relationship with Plaintiff which predated the treatment at MCGH at issue," (2) plaintiff's emergency room expert, Dr. Baker, was not qualified pursuant to *MCL 600.2169* to offer such expert testimony because he did not devote a majority of his professional time to the practice of emergency medicine in 1997 but, instead, worked half-time in emergency medicine, and (3) even if Dr. Baker was qualified to testify, plaintiff failed to establish causation.

On March 1, 2002, Dr. Kaner and Tri-County Neurological Associates moved for summary disposition, pursuant to *MCR 2.116(C)(10)*, arguing that plaintiff failed to establish a breach in the standard of care since his neurology expert, Dr. Mauskop, indicated that "if the facts of the case were consistent with Dr. Kaner's testimony, then no violation [*3] of the standard of care existed."

On March 13, 2002, plaintiff responded to MCGH's motion for summary disposition and stipulated that MCGH could not be held vicariously liable for the actions of Dr. Kaner. Plaintiff argued, however, that (1) Dr. Baker was qualified as an expert in emergency medicine as evidenced by his testimony that, in 1997, he worked eight to ten shifts a month when full-time was considered fourteen shifts a month and, further, by his affidavit attached for consideration which indicated that in the immediately preceding year he devoted a majority of his professional time to the active clinical practice of emergency medicine, (2) *MCL 600.2169* did not apply to the action because, at the time the lawsuit was filed, the statute was adjudicated unconstitutional, (3) plaintiff's causation expert, Dr. Mauskop, testified that an occluded

carotid artery could have been detected at his initial presentation to MCGH with proper testing, and (4) Dr. Larkin's and Dr. Kaner's testimony could be used to establish a breach in the standard of care and proximate cause.

On March 29, 2002, a stipulation and order dismissing, with prejudice, Dr. Kaner and [*4] Tri-County Neurological Associates was entered by the court. On May 16, 2002, the trial court issued its opinion and order granting MCGH's motion for summary disposition pursuant to *MCR 2.116(C)(8)* and (C)(10). The trial court held that (1) *MCL 600.2169* applied to the case, (2) Dr. Baker was not qualified under *MCL 600.2169* because he admitted in his deposition that he considered himself to work only half-time and, thus, did not devote a majority of his professional time to the practice of emergency room medicine, (3) Dr. Mauskop testified that he would not offer testimony as to the standard of care relative to emergency room physicians or other physicians involved in the original hospitalizations and, thus, was neither qualified nor prepared to testify as to emergency room care rendered to plaintiff, and (4) plaintiff's reliance on Dr. Larkin and Dr. Kaner as experts was unsupported because the record did not reflect that either physician was qualified under *MCL 600.2169* or that either could establish the standard of care or breach of such standard of care. Accordingly, the case was dismissed. This appeal [*5] followed.

Plaintiff argues that the trial court erred in prohibiting Dr. Baker from testifying in this case because he was qualified under *MCL 600.2169* to render expert testimony. We disagree. The qualification of a witness as an expert, and the admissibility of such testimony as evidence, are in the trial court's discretion and will not be reversed on appeal absent an abuse of that discretion. *Mulholland v DEC Int'l Corp, 432 Mich. 395, 402; 443 N.W.2d 340 (1989).*

To establish a prima facie case of professional negligence in a medical malpractice action the plaintiff must prove the applicable standard of care, breach of that standard, and an injury caused by that breach. See *Weymers v Khera, 454 Mich. 639, 655; 563 N.W.2d 647 (1997).* Expert testimony is mandatory, with few exceptions. *Locke v Pachtman, 446 Mich. 216, 223224, 230; 521 N.W.2d 786 (1994); Carlton v St John Hosp, 182 Mich. App. 166, 171; 451 N.W.2d 543 (1989). MCL 600.2169* imposes requirements regarding the qualifications of expert witnesses [*6] who would render such testimony, and provides:

> (1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> * * *
>
> (b) Subject to subdivision (c), during the year immediately proceeding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:
>
> (i) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of that specialty.
>
> (ii) The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, an accredited health professional school or accredited residency or clinical research program in the same specialty. [*7]

In this case, the trial court concluded that Dr. Baker did not devote a majority of his professional time to the active clinical practice of emergency medicine or the instruction of students in emergency medicine. We agree with the trial court.

Dr. Baker testified, in pertinent part, as follows:

> *Q.* And in 1997, which was the time frame in question in this particular case, were you working full-time as an ER physician?
>
> *A.* In 1997, I was basically half-time in emergency medicine. I was working at MacNeal Hospital, doing eight to ten shifts a month. The full-timers were doing about 14.

> *Q.* When did you - what was the first year you started becoming half-time in ER? *A.* Well, in terms of half-time clinical, it was when I left the University of Chicago. I decided I wasn't going to work any more hundred hour weeks. *Q.* I don't blame you. So after 1987, at least from a clinical standpoint, after leaving the University of Chicago, you have been half-time in ER medicine, correct, from a clinical standpoint?
>
> *A.* Yes.

Dr. Baker's testimony was clear and unequivocal--he did not devote a majority of his professional [*8] time to the active clinical practice of emergency medicine for about the ten years preceding the date of the occurrence that gave rise to this action. Although he testified that he averaged 20 to 24 hours a week, he also testified that he considered himself to be half-time clinical because he spent one day a week reviewing cases as an expert witness, "another day a week doing medical education-related things, mostly related to my own CME" and he spent "a significant amount of time working on overseas programs, mostly in Russia and the former Soviet Union." In our opinion, Dr. Baker's own interpretation as to his employment status, i.e., that he did not devote a *majority* of his professional time to active clinical practice, is the most reliable and must prevail over any nullifying interpretation, including his submission of a later, contrary affidavit. See *Dykes v William Beaumont Hosp, 246 Mich. App. 471, 479-480; 633 N.W.2d 440 (2001).* And, in light of the facts, his interpretation appears accurate. Further, Dr. Baker did not formally instruct students in emergency medicine. Practicing medicine in a teaching hospital does not fulfill the requirements [*9] of *MCL 600.2169(1)(b)(ii).* Accordingly, we do not agree with the dissenting opinion that the trial court abused its discretion in disqualifying Dr. Baker as an expert witness under *MCL 600.2169.* Considering the facts on which the trial court acted, we cannot say that its decision was without justification or excuse, *Ellsworth v Hotel Corp of America, 236 Mich. App. 185, 188; 600 N.W.2d 129 (1999),* or was "so palpably and grossly violative of fact and logic that it evidences perversity of will, a defiance of judgment, or the exercise of passion or bias," *Barrett v Kirtland Community College, 245 Mich. App. 306, 325; 628 N.W.2d 63 (2001).*

Next, plaintiff argues that the trial court abused its discretion in prohibiting Dr. Mauskop from testifying on the issue of causation. We disagree. After the trial court noted that plaintiff's only remaining claims were against MCGH and were related to emergency room visits, it held that Dr. Mauskop, a neurologist, was not qualified under *MCL 600.2169* to offer expert testimony regarding treatment rendered to [*10] plaintiff by emergency room physicians. In his appeal brief, plaintiff does not address this finding, but merely argues that Dr. Mauskop was qualified to testify as to the issue of causation. However, even if Dr. Mauskop was qualified to testify as to the issue of causation, he was not qualified to testify as to the standard of care and breach of the standard of care related to the treatment rendered by emergency room physicians during the emergency room visits. Therefore, this is not a ground on which to reverse the trial court's grant of summary dismissal.

Finally, plaintiff argues that he should be able to elicit the necessary causation testimony from the former defendants, Drs. Larkin and Kaner, to establish his prima facie case. We disagree. As noted by the trial court, the record did not establish that either physician was qualified under *MCL 600.2169* to render such expert testimony. Contrary to plaintiff's argument on appeal that "the qualifications of these doctors to testify as experts cannot be seriously disputed," both physicians could actually devote only half of their professional time to the practice of neurology and emergency room medicine. [*11] Accordingly, plaintiff failed to establish that the requirements of *MCL 600.2169* have been met with regard to either physician.

Further, even if Dr. Larkin was qualified to render expert testimony as to the applicable standard of care related to plaintiff's emergency room visits, his testimony regarding a breach of that standard and causation consisted of, as held by the trial court, "nothing more than conjecture concerning 'inappropriate' behavior hypothetically attributed to an emergency room nurse." And, even if Dr. Kaner was qualified to render causation testimony, he was not qualified to testify as to the standard of care and breach of the standard of care related to the treatment rendered by emergency room physicians during plaintiff's emergency room visits. Therefore, this issue is without merit. In sum, the trial court properly granted summary disposition in MCGH's favor because plaintiff lacked sufficient expert testimony to establish a prima facie case of medical malpractice.

Affirmed.

/s/ Bill Schuette

/s/ Mark J. Cavanagh

CONCURBY: Helene N. White (In Part)

DISSENTBY: Helene N. White (In Part)

DISSENT: WHITE, J. (*concurring in part and dissenting* [*12] *in part*).

I respectfully dissent from the majority's determination that the trial court properly disqualified Dr. Baker as an expert witness. Dr. Baker, who is board-certified in emergency medicine, never testified that he did not spend a majority of his time in ER clinical practice. Dr. Baker testified that in 1997 he spent twenty to twenty-four hours a week in ER clinical practice. He also testified that in 1997 he was doing eight to ten shifts of ER a month, while the full-timers were doing about fourteen shifts. Clearly, that is more than "half-time," and Dr. Baker's use of that term at his deposition was an approximation, as his testimony makes clear:

> *Q*. During the 1997 period that's the issue--the focus on what the case is here, half of your time was spent in ER clinical. And what were you doing with the rest of your professional time?
>
> *A*. Well, I spent -and, you know, I sort of say half-time, but it was actually more than 20 hours a week because we also worked 12-hour shifts. We worked eights and twelves, so it was on the average of say, 20 to 24 hours a week. But, you know, I considered myself to be half-time clinical. I spend about one day a [*13] week doing this sort of stuff. I spend about another day a week doing medical education related things, mostly related to my own CME. And then at that time, I was spending a significant amount of time working on overseas programs, mostly in Russia and the former Soviet Union.

Thus, I disagree with the majority's assertion that Dr. Baker's testimony was "clear and unequivocal--he only devoted half of his professional time to the active clinical practice of emergency medicine . . . " Dr. Baker's enumeration of how he spent his days, cited by the majority as evidence that he did not devote more than half his time to ER clinical practice, was in response to questioning regarding what else he did with his time, i.e., what he did with his time beyond the more than half-time he devoted to ER clinical practice.

Further, Dr. Baker's affidavit does not contradict his deposition testimony. The affidavit states "I devoted a majority of my professional time to the active clinical practice of emergency medicine in the year immediately preceding the events in question," which is completely in keeping with Dr. Baker's deposition testimony.

I agree with the majority's rejection of plaintiff's [*14] remaining arguments. With respect to Dr. Mauskop, plaintiff failed to show that he actually provided adequate proximate cause testimony. Regarding Drs. Larkin and Kaner, plaintiff failed to show that they in fact would provide testimony on violation of the standard of care or that any violation was a proximate cause of injury.

/s/ Helene N. White

STATE OF MICHIGAN
IN THE SUPREME COURT

SHIRLEY HAMILTON, as Personal Representative of the Estate of ROSALIE ACKLEY, Deceased,

Plaintiff-Appellee

and

BLUE CROSS/BLUE SHIELD OF MICHIGAN

Intervening Plaintiff

vs.

MARK F. KULIGOWSKI, D.O.,

Defendant-Appellant

Supreme Court No. 126275
Court of Appeals No. 244126
Lower Court No. 00-033440-NH

PROOF OF SERVICE

STATE OF MICHIGAN)
)ss
COUNTY OF WAYNE)

Penny L. Milliken, being first duly sworn deposes and says that she is employed with the law firm of KERR, RUSSELL AND WEBER, PLC, attorneys for Amicus Curiae Michigan State Medical Society, and that on the 6th day of September, 2005, she caused to be served via U.S. Mail, two copies of the foregoing Motion of Michigan State Medical Society for Permission to File an Amicus Curiae Brief, Amicus Curiae Brief of Michigan State Medical Society and Proof of Service, on:

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I certify and declare under penalty of perjury that the foregoing is true and correct.

Penny L. Milliken

Subscribed and sworn to before me
this 6th day of September, 2005.

PAULA A. LONGWELL
Notary Public, Wayne County, MI
My Commission Expires : 07-12-2007
Acting in the County of Wayne